International Psychogeriatrics (2009), Vol. 21, Supplement 2, S12–S50 © 2009 International Psychogeriatric Association
doi:10.1017/S1041610209009314 Printed in the U.S.A.

Symposia

SO1.1

Atypical antipsychotics: The harm outweighs the benefit

Nathan Herrmann

University of Toronto, Canada

The evidence regarding the significant association of atypical antipsychotics with increased mortality, strokes, accelerated cognitive decline and other serious adverse events will be presented. It will be argued that the modest short term benefits, mainly restricted to the single symptom of agitation, cannot possibly justify the substantial risk to health and life.

SO1.2

Atypical antipsychotics: An evidence based treatment for severe BPSD

Clive Ballard

Wolfson Centre for Age Related Diseases, United Kingdom

The evidence for significant benefit in the treatment of aggression and psychosis in people with Alzheimer's disease using antipsychotic agents such as risperidone and aripiprazole will be presented. It will be argued that with 18 RCTs, atypical antipsychotics provide by far the most evidence based treatment approach.

SO1.3

Non-pharmacological treatments: An effective and safe alternative

Akira Homma

Tokyo Metropolitan Institute of Gerontology, Japan

The evidence for the value of non-pharmacological interventions, including psychological treatments, environmental modifications, carer training and psychological interventions will be presented, drawing from evidence arising from more than 200 clinical trials. It will be argued that these interventions, if used properly, are a safe and effective alternative to atypical antipsychotic drugs.

SO1.4

Pharmacological and non-pharmacological alternatives to atypical antipsychotics

Frans Verhey

University Hospital Maastricht, Netherlands

The evidence regarding the most promising alternatives to atypical antipsychotics will be presented, and it will be argued that the evidence base is far too limited to inform clinical practice. It will also be argued that whilst non-pharmacological treatments may help some mild BPSD symptoms, they are not a viable alternative to atypical antipsychotics.

SO2.1

Modifying home environments to enhance well-being in functionally vulnerable elders

Laura N. Gitlin

Jefferson University, United States

Older adults with functional difficulties are at risk for relocation, poor quality of life, functional decline and mortality. We conducted a prospective two-group randomized trial with 319 community-living adults 70 years or older who reported difficulty with daily activities. The 6-month intervention, Advancing Better Living for Elders (ABLE program) involved instruction in strategies of problem-solving, energy conservation, safe performance, and fall recovery techniques, and balance and muscle strength training from occupational and physical therapists and implementation and training in use of home modifications over a 6 month period to address client-identified functional goals. Three follow-up telephone calls to support strategy use occurred over the following 6-months. We found that at 6-months, compared to a usual care control group, ABLE participants had less difficulty with instrumental activities ($p = .044$, 95% CI = –0.28, –0.00) and self-care activities ($p = .033$, 95% CI = –0.24, –0.01), with largest reductions in bathing ($p = .015$, 95% CI = –.51, –.06) and toileting ($p = .049$, 95% CI = –.35, –.00); greater self-efficacy ($p = .025$, 95% CI = 0.02, 0.27); reduced fear of falling ($p = .001$, 95% CI = 0.26, 0.96); fewer observed home hazards ($p = .050$, 95% CI = –3.06,.00); and greater use of positive adaptive

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

strategies (p = .009, 95% CI = .03,.22). Benefits were sustained at 12-months for most outcomes. Of significance is that by 12 months, ABLE participants exhibited a 1% mortality rate compared with a 10% rate for control participants (P = .003, 95% confidence interval) and at two years, ABLE participants (n = 160) had a 5.6% mortality rate (n = 9 deaths) compared to controls (n = 159) who had a 13.2% rate (n = 21 deaths; p = .020). Mortality rates remained relatively lower for ABLE participants up to 3.5 years from study entry. The ABLE trial shows that helping older adults modify their task performance and home environment has enduring effect on their well-being resulting in extended survivorship. ABLE presents as a low-cost clinical tool to delay both functional decline and mortality and should be included in the standard of care for older functionally vulnerable elders.

SO2.2

Stove-timer devices as support to older adults with cognitive impairment or dementia

Louise Nygård, Ph.D

Karolinska Instiutet, Sweden

It is today common to provide a timer attached to the stove to older adults with cognitive impairment or dementia in order to promote their ability to remain living at home. Little is however known of the characteristics and experiences of these stove-timer users and their families as well as of the reasoning and grounds for action of professional stakeholders involved in the intervention process. In order to shed light on these issues, three studies were undertaken with the overall purpose to gain new knowledge of the usability of stove timers for users with cognitive impairment or dementia, and to better understand how assistive technologies such as stove timers could be provided and introduced to meet these users' needs. To learn about the user group, we started out with identifying the characteristics of all persons (n = 945) who applied for and were provided with stove timers in an urban Swedish municipality in 2002. We also investigated the application procedures and timer settings. We found that most users were very old females with unspecific memory impairment. The options available for tailoring the use of the device were not used consistently, and professional follow up was often lacking. The device seemed to be used as a safety precaution rather than as a device to support activity performance based on individual needs. To bring further clarity to what this meant to the users, we qualitatively explored users' and relatives' experiences of receiving and using a stove timer, and found that users were little involved in the process. Although they felt the device provided increased safety it also brought about unforeseen difficulties and challenges and users were left alone with learning how to manage it. In the final sub-study, we explored the reasoning and views of different professional stakeholders involved in providing stove timers and supporting older adults with cognitive impairment or dementia at home, and sought to illuminate how their views guided their actions. We found that initially all informants agreed on the purpose of the stove-timer being to ensure safety, and on the importance of timing and clients' motivation. However, the stakeholders' views and actions regarding their older clients as stove timer users differed from thereon in aspects related to their perceptions of learning, responsibility, who the user is, and what the stove timer is. The initial, shared goal resulted in a lack of support to clients once the timer had been installed and hence the device could bring about uncertain ends and unwanted consequences, rather than being protective. The findings exemplify how users strive to relate to and make sense of technology that in fact is meant to be invisible and self-instructing, suggesting that home modifications with assistive technology should pay more attention to the interaction between the technology and the user and always include follow-up. The users, e.g. people with cognitive impairment or dementia and their families, should be more actively involved in a process-oriented approach.

SO2.3

Assistive technology for older persons with cognitive impairments or dementia

Lena Borell, Ph.D

Karolinska University Hospital, Sweden

Aging in place at home has for many years been a political goal in many countries, and is what most older adults look forward to also in the case of cognitive impairment or dementia. The challenge for national welfare systems is to enable housing and societal conditions where the older adult with cognitive problems will feel safe and secure. Home-modifications and environmental adaptations, assistive devices and home-rehabilitation are all possible services that can enable and support aging in place at home. Still, there is a lack of knowledge about what the interventions that will enable aging at home and home making activities should consist of. Cooking

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

and using technology developed for use in the kitchen is one of the domestic activities that can not only be difficult to carry out but also a threat to safety in the case of a person with dementia.

New technology and assistive devices are now rapidly developing that can have a potential to meet the needs not only for safety but also to support independent home-making. Assistive technology, such as reminders based on ICT systems, has rapidly developed, although their usability has been little researched so far. In order to be useful, pieces of technology need to be designed and integrated and often tailored to the specific needs of each individual client. Guidelines are now developing to support and implement the use of new technology in the homes of people who wish to remain aging in place at home.

A model for a "cognitive" kitchen based on research and focus group discussions carried out with clients and families in Sweden will be introduced. The outcome for clients, caregivers, and family home-helpers when IT based technology is implemented in the home will also be discussed.

SO3.1

Neurocognitive impairment in younger and older adults with major depression

Alan Thomas

Newcastle University, Newcastle upon Tyne, United Kingdom

Cognitive impairment occurs in younger and older adults with depression and the pattern appears similar. Although it is generally believed the deficits are more severe in older people only a few studies have directly examined this. Late-life depression appears to be associated with greater executive dysfunction and impairment in verbal learning and memory than can be explained by the effects of older age alone. This evidence, including our recently completed study, will be reviewed and placed in context.

SO3.2

Predictors of cognitive decline in the Neurocognitive Outcomes of Depression in the Elderly (NCODE) study

David Steffens

Duke University, Durham, NC, United States

NCODE is an NIMH-supported longitudinal study of depression in older adults. Cognitive decline and development of dementia are key outcomes of the study. Depressed patients and non-depressed elderly controls are followed with clinical and social assessments and agree to serial magnetic resonance imaging (MRI) brain scans, a blood draw for genetic analysis, and annual cognitive testing. This symposium will highlight biological and social factors related to cognitive decline, including structural changes seen on MRI, a variety of risk genes, social stress and social support measures.

SO3.3

Persistent cognitive impairments in late-life depression: Impact of disease state and trait features

Kohler Sebastian

Maastricht University, Maastricht, Netherlands

Cognitive deficits are persistent in late life depression, but there might be undetected variability caused by specific patient characteristics. We compared sixty-seven patients and 36 healthy controls on global cognition, memory, executive functioning and processing speed at baseline, 6 and 18 months. Patients performed worse across all cognitive domains at all time points, without significant variability due to current mood, remission status or antidepressant treatment. Late onset patients showed worse memory performance. Deficient processing speed did not fully explain the results. Cognitive deficits in late life depression affect multiple domains and may reflect irreversible structural brain lesions.

SO3.4

Is there a role for cognitive remediation in older people 'at risk' of cognitive decline?

Sharon Naismith

Sydney University, Sydney, NSW, Australia

Older 'at risk' cohorts include people with vascular risk factors, mild cognitive impairment and late-life depression. These groups often have neuropsychological deficits that do not resolve with pharmacological treatment. Such deficits are predictive of disability, poor prognosis and progression to dementia. Non-pharmacological techniques offer some promise in this area, particularly those targeting 'modifiable' risk factors and those that specifically target cognition. This presentation will determine whether there is a role for early intervention of cognitive deficits in these 'at risk' cohorts and in particular, whether there is a role for cognitive remediation.

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SO4.1

Subjective cognitive impairment: The pre-MCI stage of AD: Antecedents and consequences

Barry Reisberg[1]; Serge Gauthier[2]; Melanie Shulman[1]; Carol Torossian[1]; Wei Zhu[1]; Istvan Boksay[1]; Isabel Monteiro[1]; Leslie Prichep[1]; Lisa Mosconi[1]; Alok Vedvyas[1]; Imran Jamil[1]; Mony de Leon[1]

[1]New York University School of Medicine, New York, NY, United States; [2]McGill Center for Studies in Aging, Montréal, Canada

We have been studying subjective cognitive impairment (SCI) in otherwise healthy persons free of depression or other psychopathology (primary idiopathic SCI). We find that: (1) this is a stage in the development of MCI and eventual Alzheimer's disease (AD) lasting ~15 years and, (2) behavioral, electrophysiologic, neurometabolic (PET), and hormonal markers and predictors of outcome in this stage have been identified in recent studies. We now report the finding of even earlier psychometric predictors of SCI in normal older persons free of subjective impairment (NCI). These findings can be applied towards AD prevention studies decades prior to manifest dementia.

SO4.2

Which definition of MCI predicts progression?: A population based study

Henry Brodaty; Perminder Sachdev; Nicole Kochan; Simone Reppermund; Melissa Slavin; Kristan Kang; John Crawford; Lee-Fay Low

University of New South Wales, Sydney, NSW, Australia

A population based cohort of 1037 persons without dementia received comprehensive clinical and neuropsychological evaluations, blood tests and (for >50%) MRI scans. Rates of Mild Cognitive Impairment varied with interpretation of definitional criteria from 19 to 34.5%. We examine which definitions predict progression to dementia.

SO4.3

Predicting MCI and Alzheimer's disease using MRI brain imaging and CSF studies

Philip Scheltens; W. Van Der Flier; Frederik Barkhof

VU University Medical Center, Amsterdam, Netherlands

MRI and CSF are the two biomarkers in dementia that have been studied most extensively. Separately, they seem to be able to diagnose AD and predict AD. Serial MRI is also capable of following the disease process. Few studies have addressed their combined value in the diagnostic process, which will be highlighted during this presentation.

SO4.4

MCI of depression: Nature and outcome

John O'Brien; Alan Thomas; Sebastian Koehler

Newcastle University, Newcastle upon Tyne, United Kingdom

Depression is strongly associated with memory complaints, and deficits persist despite clinical recovery in those with late life depression. However, the "MCI" of depression has received little attention to date. Using new data from our own and other studies, this presentation will examine the significance, possible etiology, and longer term outcome of cognitive impairments in depression.

SO5.1

Relation of clinical etiological subgroups of delirium to prevention, onset, precipitating factors, symptoms, treatment and outcome of delirium

Jouko Laurila

Helsinki University Central Hospital, Helsinki, Finland

The classification of delirium into hyperactive, hypoactive ("silent") and mixed type according to the symptomatology of the syndrome has not yet shown generally accepted criteria nor much clinical relevance outside the detection rate, treatment options, and merely evolving data on possible differences in pathophysiology of these phenomenological subtypes.

While the clinical research protocols among delirious patients are performed mainly among either general medical inpatients, perioperative (hip fracture) patients, or terminal patients—often by totally different research groups—these three "clinical etiological subgroups" may deserve further evaluation within and between the subgroups. Prevention of geriatric delirium is shown to be effective in up to 34% and perioperative delirium in up to 36% of the patients. Pharmacologic prevention is shown to be effective only among perioperative patients.

When the present growing body of evidence on delirium is analyzed according to these clinical etiological subgroups, very basic differences can

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be found among the prevention, but also among onset, precipitating factors, outcome (duration), symptomatology, and even treatment options of the syndrome.

Conclusion: While neither the pathophysiologic nor phenomenologic research on delirium has yet gained much strong evidence supporting the differences between the three symptomatologic subtypes of delirium, it may be clinically advantageous to assess the syndrome according to the three clinical etiological subtypes. This may even help the clinician to better understand the multiplicity of this devastating syndrome.

SO5.2

Delirium after cardiac surgery

Edward Marcantonio

Harvard Medical School, Boston, MA, United States

Background: Delirium (acute confusion) is a common, morbid, and costly complication after non-cardiac surgery. Delirium after cardiac surgery, while felt to be common, has been less well studied. Since the age of patients undergoing cardiac surgery is ever increasing, this is an important topic for further investigation.

Methods: We enrolled 231 patients aged 60 and older undergoing coronary artery bypass grafting (CABG), or combined aortic or mitral valve replacement and CABG (valve/CABG), at three regional medical centers. Preoperatively, we performed a detailed baseline assessment, including tests of cognitive and functional status. Starting on postoperative day 2, patients underwent daily structured mental status assessment and delirium was diagnosed using the Confusion Assessment Method (CAM). For intubated patients, we used the CAM-ICU. We reassessed patients' cognitive and functional status at 1, 6, and 12 months after surgery, usually by performing a home visit. We also performed detailed medical record reviews to obtain information on medical comorbidity, intraoperative course, and complications. To derive a clinical prediction rule for delirium, we divided our cohort into a derivation and validation sets, and used multivariable logistic regression. For analysis of functional outcomes, we used Poisson regression to examine decline in Instrumental Activities of Daily Living (IADLs).

Results: Of our 231 patients (mean age 74±7 years, 77% men), 78% had CABG and 22% had valve/CABG, with almost all surgery performed "on pump" (97%). Postoperatively, 111 (48%) developed delirium, with a median duration of 2 days. In our clinical prediction rule, we identified 5 preoperative risk factors for delirium and assigned them the following point values: Mild cognitive impairment = 1 point, Moderate cognitive impairment = 2 points, History of stroke/TIA = 1 point, Depressive symptoms = 1 point, Abnormal albumin = 1 point. In our independent validation dataset, patients with 0 points had a 18% risk of delirium, those with 1–2 points had a 50% risk, and those with 3 or more points had a 87% risk (area under the ROC = 0.75). We also found that delirium was associated with decline in IADL function one month after surgery RR = 1.9, [95% C.I. 1.3, 2.8] and a trend toward decline 12 months after surgery RR = 1.9, [95% C.I. 0.9, 3.8]. The one month finding remained significant after adjustment for age, comorbidity, and baseline cognitive and functional status.

Conclusions: In this cohort of older cardiac surgery patients, delirium was extremely common. Though it was often short-lived, delirium was associated with long term functional decline. We developed a clinical prediction rule for identifying patients at highest risk. This rule implies the importance of performing preoperative assessments of cognition and mood in these patients. We are currently studying precipitating factors and mechanisms of delirium after cardiac surgery to design strategies for its prevention and treatment in this important clinical population.

SO5.3

Improving the outcomes of delirium in older hospital inpatients

Martin Cole

McGill University, Montreal, QC, Canada

Delirium is a cognitive disorder characterized by acute onset, fluctuating course and disturbances in consciousness, orientation, memory, thought, perception and behavior. It occurs in hyperactive, hypoactive or mixed forms in up to 42% of older hospital inpatients, many with pre-existing dementia.

Notably, the occurrence of an episode of delirium in this population is associated with many poor outcomes, including increased cognitive impairment and functional disability, length of hospital stay, rates of institutionalization and rates of death. Interventions to address these poor outcomes would improve the lives of older people and probably reduce health care costs. To date, however, trials of different interventions (i.e. systematic detection of delirium early in the course of hospitalization, multi-faceted interventions to reduce drug use, manage medical problems optimally, increase family and nursing

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support and increase sensory cues) have not demonstrated any substantial benefits. This paper proposes that the poor outcomes associated with delirium in older hospital inpatients may be related, in large part, to the persistence of delirium in a substantial minority of these patients. Accordingly, interventions to identify this substantial minority and ensure full recovery from delirium may improve the poor outcomes.

SO5.4

Delirium: An overview

Benjamin Liptzin

Baystate Medical Center, Springfield, MA, United States

This symposium touches on a number of key issues in the classification, prediction and outcomes of delirium, a common geriatric condition especially for hospitalized elderly.

SO6.1

Prevention, detection and treatment of anxiety in dementia (Presented in French)

Francois Primeau

Hotel-Dieu de Levis Hospital (Laval University), Levis, QC, Canada

Considering the prevalence of 6.1% of anxiety disorders in the elderly population and the concomitant increase of patients with dementia, anxiety in dementia constitutes a condition whose occurrence is on the rise. Anxiety needs to be differentiated from dementia, depression and agitation. Modified generalized anxiety disorder (GAD) criteria and appropriate measure instruments to assess anxiety in dementia will be presented. Clinical characteristics of anxiety in dementia will be reviewed to enhance detection. Prevention will be ascertained in the context of the general risk and protective factors for dementia and specific etiological perspectives for anxiety. Various non-pharmacological (behavioural and cognitive) and pharmacological treatments will be assessed from an evidence-based approach.

SO6.2

Prevention, detection and treatment of depression in dementia (Presented in French)

Nadine Gagnon

Quebec City Mental Health University Institute (Laval University), Quebec City, QC, Canada

Depression is one of the most frequent comorbid psychiatric disorders in Alzheimer's disease and other dementias. The wide variation in its prevalence in Alzheimer's disease (0–86%) underlines the clinical difficulty in the diagnosis of depression associated with dementia. The various clinical presentations and differential diagnoses (e.g. dementia symptoms, anxiety, cognitive symptoms of depression without dementia) for depression in dementia will be reviewed in order to enhance recognition of this markedly underdiagnosed and disabling disorder. Appropriate assessment tools such as the Cornell Scale for Depression in Dementia and modified depression diagnostic criteria for subjects with Alzheimer's disease (NIMH provisional diagnostic criteria for depression in Alzheimer's disease) will be discussed. Prevention of depression in dementia will be addressed while reviewing potential etiological factors. We will also summarise the literature about both non-pharmacological, mostly cognitive and behavioural interventions, and pharmacological treatment options. New data of a prevalence and detection study of depression in Quebec City nursing home elderly patients with dementia will be presented.

SO6.3

Prevention, detection and treatment of psychosis in dementia (Presented in French)

Francois Rousseau

Quebec City Mental Health University Institute (Laval University), Quebec City, QC, Canada

Psychosis is reported in more than one third of elderly patients with Alzheimer's disease and related dementias. It is also a core diagnostic feature of dementia with Lewy bodies. The clinical presentation and course of psychotic symptoms in dementia are distinct compared to primary psychosis like schizophrenia. These psychotic symptoms include characteristic delusions, misidentification phenomena and hallucinations most frequently visual. Psychosis of dementia is often comorbid with or at the root of agitation, aggression, anxiety and depression. The atypical clinical picture of this type of psychosis and the confounding impact of associated cognitive impairment increase the challenge of detection and diagnosis of this condition. It is also sometimes difficult, especially in severe dementia, to clarify if the psychotic symptoms are related to delirium. Many epidemiological studies have

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identified risk factors for psychosis of dementia, severe cognitive impairment and older age being the most important. Some potential risk factors can be targeted for preventive interventions such as visual and auditive impairments, unadapted environment and use of medication with anticholinergic effects. Diagnostic criteria proposed by Jeste and Finkel in 2000 for psychosis of Alzheimer's disease will be presented. Assessment scales such as the BEHAVE-AD and the Neuropsychiatric Inventory (NPI) will be discussed as potential detection tools to enhance recognition of this disorder. A summary of the evidence-based non-pharmacological and pharmacological treatments of this condition will be reviewed. Limited therapeutic effects of antipsychotic medication and potential efficacy of cholinesterase inhibitors and memantine will be debated.

SO7

Late–life anxiety (measures, non-pharmacological interventions, and pharmacological interventions)

Gerard J. Byrne

University of Queensland, Australia

Anxiety symptoms and anxiety disorders are highly prevalent in later life, although less commonly studied than depression and dementia. Generalized anxiety commonly complicates major depression and leads to a worse prognosis. Older people with subjective cognitive complaints, mild cognitive impairment and dementia all report higher levels of anxiety than found in normal volunteers. Anxiety is associated also with general medical conditions – the greater the number of medical illnesses, the higher the anxiety.

Several self-rated and clinician-rated measures are now available to assess anxiety symptoms in older people. Some instruments employ modifications to make them more suitable for use with older people. These modifications include reductions in item complexity and ambiguity, simplification of response choices and minimisation of somatic items. Some scales have been translated into multiple languages. More experience is now needed with the use of these new scales in diverse populations of older people.

There is increasing evidence in support of the use of non-pharmacological interventions to treat anxiety in older people, particularly for those with generalized anxiety or phobic anxiety. In particular, the evidence base for the use of cognitive behaviour therapy (CBT) for this indication in older people has been steadily growing. It is unclear, however, which components of CBT are most effective in older people, particularly in the oldest of the old.

Pharmacological interventions are in widespread use for the treatment of anxiety disorders in later life, particularly for generalized anxiety disorder and posttraumatic stress disorder. The use of modern antidepressants, including SSRI and SNRI drugs, has reduced the use of benzodiazepines in some places. There are also new antidepressants with effects on the melatonergic system that may well improve insomnia as well as symptoms of depression and anxiety.

In this symposium, speakers will review the current state of late-life anxiety and will focus particularly on the measurement of anxiety, and the current evidence for the use of non-pharmacological and pharmacological treatments for anxiety disorders.

SO8.1

Driving assessment of the cognitively impaired older driver

Brian Ott

Warren Alpert Medical School of Brown University, Providence, RI, United States

Age is a proxy for physical and cognitive impairments that can impair driving. With age, right-of-way and traffic sign violations increase, and intersection:non-intersection crash ratio increases. Reaction time, visual perception, and attention become important risk factors for crashes. Drivers with dementia have approximately 2.5 to 5 times greater risk of involvement in a crash compared to age-matched controls. How can we identify those cognitively impaired older drivers at greatest risk? We will briefly review the most important demographic, cognitive, and field tests that may help to answer this question: 1) disease duration and severity, 2) gender, 3) education and occupation, 4) patient or family report, 5) cognitive measures, 6) on-road testing, and 7) driving simulator testing. Although it appears that there are identifiable factors that lead to driving impairment in individuals with dementia, there currently is no "gold standard" for assessment of risk. Due to the limitations of simulators and road tests, current research includes a scientific examination of driving performance of older drivers in the natural setting. Obtaining such information in a standardized fashion will allow comparison with formal road test performance and help us to

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

answer the debate about the validity of road testing, as well as the value of neuropsychological test predictors.

SO8.2

Sleep medication, antidepressants and traffic safety in the elderly: Evidence from on-the-road driving studies in real traffic

Joris Verster

Utrecht Institute for Pharmaceutical Sciences, Faculty of Science, Section Psychopharmacology, Netherlands

Depression and insomnia often occur in the elderly and may significantly affect their quality of life. Driving a car is an important way in which elderly preserve their independence and facilitate social contact. However, the pharmacological treatment of depression and insomnia may negatively impact driving ability and thus compromise traffic safety.

Many hypnotics and antidepressants have been examined applying the on-the-road driving test in real traffic. In this test, subjects are instructed to drive a car over a 100 km public highway while maintaining a constant speed and steady lateral position. The Standard Deviation of Lateral Position (SDLP), i.e. the weaving of the car, is the primary parameter of the test.

Benzodiazepines are the traditional pharmacological treatment for insomnia. There is considerable evidence that benzodiazepines significantly impair driving ability. Epidemiological studies confirm that traffic accident risk is significantly increased in patients who are treated with benzodiazepines. In terms of traffic safety, zopiclone, a non-benzodiazepine hypnotic, shows no advantages over benzodiazepines. Zolpidem and zaleplon (both non-benzodiazepines) do not impair driving when used as recommended. Tricyclic antidepressants (TCAs) such as amitriptyline, doxepine and imipramine comprise the traditional pharmacological treatment of depression. Unfortunately, driving is significantly impaired after treatment onset. After daily use of TCAs, tolerance develops slowly. In contrast, SSRIs (including fluoxetine, paroxetine and escitalopram) and related antidepressants (e.g., venlafaxine) do not impair driving.

Several factors may interact with the effects of drugs on driving, including normal cognitive decline during aging, the effects of insomnia and depression itself on driving, and the presence or absence of co-morbid disorders. The impact on driving further depends on various drug-related factors such as the administered dose, half-life, time between intake and driving, duration of treatment (tolerance), gender, and individual differences.

Up to now, most driving studies were performed in healthy adults. Therefore, further studies of drug effects in elderly patients are necessary. Pharmaceutical companies should focus on developing new drugs with alternative mechanisms of action, aiming at less sedation.

SO8.3

Epidemiological findings of drivers with dementia and new legal systems in Japan

Manabu Ikeda

Kumamoto University, Kumamoto, Japan

Recent studies and newspaper articles have reported that not a few individuals with dementia are still driving automobiles in Japan, causing a threat against other drivers and pedestrians. To further understand the present situation of dementia drivers in Japan, we sent a structured questionnaire to the members of the Japanese Psychogeriatric Society and those of the Japan Academy for Alzheimer's Disease. The questionnaire was distributed to 368 experts who agreed to participate in this survey (8%) with written informed consent. The subjects were 7329 outpatients with dementia who visited these experts' clinic during the consecutive three months. Seven hundred and seventy-eight patients (11%) were driving at the time of the survey, 36% among them everyday and 33% several days per week. The purposes of their driving were visiting hospital (39%), shopping (24%), social and recreational activities (18%), and work (14%). Approximately 1/3 of caregivers (34%) worried about the patient's driving and considered it dangerous, and 31% of caregivers had tried to stop it. On the other hand, only 2% of drivers with dementia had been forced to quit driving by the police/government. Not a small percent (16%) of drivers with dementia caused car accidents. In Japan, the Road Traffic Act was revised in 2008 and determined that elderly persons over 75 years of age are required to undergo a cognitive screening test on renewal of their driver's license. Those applicants whose scores are below the cut-off point of this cognitive screening, and who, in addition, have predetermined traffic violation records during the past year, would be referred to a medical expert. Once the diagnosis of dementia is determined, the Public Safety Commission holds the applicant's license accordingly. Because the Act will be valid from June 2009, we will discuss the situation of drivers with dementia in Japan under this new Act.

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SO8.4

Epidemiological studies of dementia and depression in older drivers

Mark Rapoport

University of Toronto, Canada

Clinical studies of the impact of dementia, depression, and psychotropic medication in old age have generally shown poorer performance on driving simulators and on-road tests. In order to demonstrate a real-world public health impact, however, it is necessary to assess the impact of these conditions and treatments on actual motor vehicle collisions (MVCs) on the road.

Studies pertaining to the risk of dementia on state-recorded crashes will be reviewed, and reasons for discrepancies between the studies will be explored. Factors such as behavioral disturbance may further increase the risk of collisions among patients with dementia, and preliminary evidence for this will be presented.

There has been little epidemiological research to date on the driving ability of older adults with mental illness other than dementia. Results of a European meta-analysis describing a 67% increased risk associated with depression or depressive symptoms will be discussed, as well as six epidemiological studies of the risk of MVCs associated with antidepressants. Limitations including small numbers or no patients of geriatric age, a focus on the tricyclic antidepressants, and the restriction to MVCs involving medical care, hospitalization or death, will be discussed. Retrospective and case-control designs are also limited by the inability to account for between-group differences on critical variables such as driving exposure and patterns.

The most rigorous way of assessing the risk of MVCs with antidepressants would be a randomized controlled clinical trial (RCT). However, ethical considerations would preclude the implementation of such a study using real-world MVCs as an outcome. Specifically, withholding antidepressant treatment for depressed patients, or allowing clearly unsafe depressed drivers on the road to assess road safety would preclude the ethical conduct of an RCT design. A case-crossover design is a technique used to assess the change in risk of an acute event during a relatively brief interval after exposure to a transient risk factor. The principal advantage of the case-crossover design as compared to a case-control study is the ability to cancel out fixed characteristics and confounds such as age, socioeconomic status, genetics, and intelligence. Preliminary data from a case-crossover study of the risk of antidepressants on MVCs will be discussed.

SO9.1

Sexual expression in older adults in the community and long-term care settings

Ken Schwartz

Baycrest Centre for Geriatric Care, University of Toronto, Canada

The current stereotype of the elderly as asexual persists despite studies conducted in the past 30 years challenging the idea that the elderly are not or should not be sexually active. More recent studies that focus on the attitudes of community-dwelling seniors regarding the role and importance of sex in their lives will be discussed. Unfortunately, myths and misconceptions still abound in today's long-term care settings resulting in a lack of attention to sexuality and few opportunities for its expression. A model addressing the obligation of facilities to provide an environment ensuring the safety of all residents as well as allowing the sexual expression of interested competent residents is described.

SO9.2

Sexuality and dementia in long-term care settings: Clinical and ethical issues

Marcia Sokolowski

Baycrest Centre for Geriatric Care, University of Toronto, Canada

Resident Rights in the Ontario Nursing Homes Act will be described. Ethical questions addressing autonomy, informed consent, beneficence, nonmaleficence and personhood are discussed with the aid of a clinical case example which is viewed from a clinically relevant and perhaps controversial frame of reference. After consideration of the literature and the case-based presentation, the audience will be engaged in active participation to consider ethically relevant approaches to this complex issue.

SO9.3

Sexuality and dementia in a long-term care setting: Management of inappropriate sexual behaviours

David Myran

Baycrest Centre for Geriatric Care, University of Toronto, Canada

The presentation will identify the issues that arise when residents with dementia are considered to

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

exhibit sexually inappropriate behaviour in the long-term care setting. Topics to be discussed are the various definitions, prevalence, etiology, and treatments of sexually inappropriate behaviour. When psychiatrists and other clinicians who work in the long-term care setting are asked to intervene to manage what is perceived to be inappropriate sexual behaviour it is particularly important that a careful diagnostic assessment of the resident be performed in order to guide the various behavioural, environmental and pharmacotherapy interventions. The presentation will include discussion on how to assess competency to engage in sexual relationships when one or both of the partners suffer from dementia.

S10.1

Evidence and innovation: The science of caring for family caregivers

Joel Sadavoy

University of Toronto, Toronto, ON, Canada

Family caregivers are at high risk from burden and stress; the burden of caregiving for dementia at home arises from a complex interplay between caregiver factors (including knowledge/skills, interpersonal/family/social, psychological/personality/developmental, and health), and care recipient factors (most notably BPSD). The development of innovative evidence-based programs in a new centre created to address each of the complex but often modifiable factors of caregiver burden is described, including innovative use of standardized patients to train family caregivers in skills of dementia caregiving.

S10.2

Translating an evidence-based intervention for spouse-caregivers into community settings

Mary Mittelman

NYU Langone School of Medicine, New York, NY, United States

The NYU Caregiver Intervention has demonstrated efficacy in a randomized controlled trial, and is now being replicated in community settings. The original intervention had significant effects on social support, symptoms of depression, reactions to patient behavioral symptoms and self-reported health of spouse-caregivers, which resulted in major delays in nursing home placement of patients. Several community translations are currently underway. The intervention is being implemented in Minnesota among rural and underserved minority as well as urban caregivers through a partnership including the Minnesota Board on Aging, Alzheimer's Association MN/ND Chapter, 8 Area Agencies on Aging, a county public health agency, medical clinic and memory disorders clinic. Another community translation is being implemented through physicians' practices in rural Vermont. There are two translations in New York City, one in a Medicaid Managed Care agency with a mandate to help low income minority older adults with chronic illness remain at home, and the other in a senior service agency whose clientele are of Latino background. We will describe the intervention, barriers, challenges, adaptations and achievements in the community replications.

S10.3

The 3-country study: Effects of counseling for families of people with Alzheimer's disease on donepezil

Henry Brodaty

Prince of Wales Hospital, Sydney, NSW, Australia

In the first multinational randomised controlled trial of a psychosocial intervention combined with pharmacotherapy, all 158 persons with Alzheimer's disease (AD) received donepezil while half of their caregivers received five sessions of counseling over three months—two sessions for their spouse and three for the more extended family—as well as ad hoc counseling upon request for up to two years. Caregiver depression levels decreased for the intervention group whereas levels increased in caregivers receiving usual care, diverging further over two years of follow-up. There were no differences in nursing home placement or mortality between the treatment and control groups over 8.5 years of follow-up, but there were by country with Australian patients admitted earlier than U.K. and U.S. subjects. That counseling appeared to delay institutionalization in Australian patients, may have been related to its interaction with that country's health system or to more ad hoc counseling received subsequent to the intervention.

S10.4

Mastery over dementia: Online counseling for family caregivers of people with dementia

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

Anne Margriet Pot

Netherlands Institute of Mental Health and Addiction, Utrecht, Netherlands

Web-based interventions offer a very promising source of support for family caregivers of people with dementia, especially in view of the characteristics of the competing demands and limited time available to many caregivers. In addition, web-based interventions might be less stigmatizing compared to care provided by a mental health institute, which may be important for caregivers who often don't see themselves as the ones who need help, because they are focused on the needs of the person with dementia.

This presentation will be focused on the first web-based intervention, i.e. 'Mastery over dementia,' for family caregivers of people with dementia. 'Mastery over dementia' is a preventive intervention under the guidance of a professional counselor, and consists of 8 sessions and a booster session after one month. It is focused on decreasing depressive symptoms and caregiver burden. The internet course consists of interactive learning on how to cope with behavior problems and care-problems and make a plan for what to do in crisis situations (problem solving techniques), changing upsetting thoughts (cognitive behavioral techniques); relaxation and doing pleasant activities; learning to become more assertive; and mobilizing social support. This is in line with the latest evidence on the effective elements of face-to-face interventions to reduce caregiver burden and depressive symptoms.

'Mastery over dementia' is developed by the Netherlands Institute of Mental Health and Addiction in collaboration with Alzheimer Netherlands and health care provider Foundation Geriant. This innovative intervention will be shown and first results will be presented.

S11.1

Small group living homes for people with dementia: Do or don't? An introduction

Anne Margriet Pot

Netherlands Institute of Mental Health and Addiction, Utrecht, Netherlands

As an introduction to the presentations of this symposium, the different types of intramural psychogeriatric care for people with dementia, including small group living homes, will be illuminated. In addition, the knowledge about the differences in quality of care, residents' functioning and quality of life, and job-satisfaction and burnout of nursing staff in small group living homes compared to other intramural psychogeriatric facilities will be summarized briefly.

S11.2

The comparison of residents' functional status and cognition in small group living homes and regular psychogeriatric nursing home wards

Hilde Verbeek

Maastricht University, Maastricht, Netherlands

Introduction: Whether characteristics of residents living in small-scale living facilities differ from residents in regular psychogeriatric wards is relatively unknown. This study compared functional status and cognition of residents living in small-scale living facilities with those living in regular psychogeriatric wards in large nursing homes.
Design: A cross-sectional study was conducted in the Netherlands, using two subscales from the Resident Assessment Instrument (RAI) Minimum Data Set (MDS): the ADL-Hierarchy scale (ADL-H) and the Cognitive Performance Scale (CPS). In addition, background variables age, gender, living condition prior to admission and length of stay were recorded. A total number of 766 residents was included: 182 in small-scale living facilities and 584 in regular psychogeriatric nursing home wards.
Results: Significantly better results ($p<.01$) were found in both ADL-H and CPS scores for residents in small-scale living facilities compared to those living in regular psychogeriatric wards. In addition, significantly more residents in regular psychogeriatric wards lived at home prior to admission, as opposed to residents in small-scale living facilities, who were more often transferred from a regular ward. Moreover, length of stay was significantly higher for residents in regular psychogeriatric wards. There were no differences in age between residents.
Discussion: Our results suggest that residents in small-scale living facilities may have a better functional status and cognition, compared with residents in regular psychogeriatric wards in nursing homes. Background variables such as length of stay might explain a part of these differences. In addition, it is suggested that some of the small-scale facilities might apply selection criteria for residents' admission. Functional status and cognition could be important aspects in this selection process. Future research should use a longitudinal design to examine the course of residents' characteristics

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

in both settings. Additionally, other characteristics such as behavioral problems and social functioning should be studied.

S11.3

The comparison of residents' well-being, job satisfaction and burnout of nursing staff, and quality of care in small group living homes and several other types of intramural psychogeriatric care

Bernadette Willemse; Dieneke Smit

Netherlands Institute of Mental Health and Addiction, Utrecht, Netherlands

Introduction: To provide small group living care, new nursing home facilities are being built or existing facilities are adjusted. As a result, there is a wide range of facility types available providing nursing home care. Five types can be identified in the Netherlands: the traditional large scale nursing home, a large nursing home where small scale care is provided, group living homes nearby the mother facility, stand-alone group living homes in the community and nursing home wards in a home for the aged. The question arises where the 'best' care is provided in terms of quality of care and quality of life of the residents, but also in terms of affordable care. Moreover, regarding the expected personnel shortage, it is important to explore the determinants of the care provided by facilities organized efficiently (low staff number) and where the nursing staff is satisfied. The Dutch Monitor Living Arrangements for People with Dementia funded by the Ministry of Health is designed to answer these questions.
Design: We randomly selected 150 facilities, 30 facilities per type, to participate in this Monitor. In each facility a care manager was interviewed, 15 randomly selected nursing staff members were asked to fill out a questionnaire, and CNA's were asked to fill out a questionnaire about 12 randomly selected residents. The primary outcomes of the quantitative part of this study are resident and staff well-being, quality of care and occupation of nursing staff. For the qualitative part, ten nursing home facilities with a relatively low occupation of nursing staff in combination with a relatively good performance on the primary outcomes will be identified as best-practices. Focus groups with managers, physicians, psychologists, and nursing staff of the residents with dementia will be held to determine the factors contributing to the efficient occupation of nursing staff and good overall quality of these nursing home facilities.
Results And Discussion: Till now the care managers in all 150 facilities are interviewed, 1076 (53%) nurses returned the questionnaire and 1176 (72%) CNA's answered the questionnaire concerning the residents already. At the congress, results of the quantitative part comparing residents' well-being, job satisfaction and burnout of nursing staff, and quality of care in small group living homes and the other types of intramural psychogeriatric care, will be presented and discussed.

S11.4

Does the design of a group living unit for demented elderly make any difference?

Sölve Elmståhl

Lund University, Malmö, Sweden

Introduction: In Sweden, specially designed living for demented elderly, so called group living unit (GL), has been implemented in the past decades. Few studies have focused on the impact of the design of living conditions for demented elderly, their behavioural and psychological symptoms and caregivers' burden.
Design: Two study populations were analysed: 79 subjects in need of GL care and their caregivers were interviewed and assessed prior to relocation to a GL and 105 subjects with dementia living in 18 GL were followed for 12 months. Assessment included a caregiver burden scale (CBS), the Organic Brain Syndrome scale for behavioural and psychological symptoms (BPSD) in dementia and a standardised scale for environmental screening (TESS-2).
Results: BPSD, especially loss of identity and hallucinations, are significant predictors for burden among caregivers. The degree of cognitive decline was related to caregiver burden, especially general strain and isolation. Most of the studied GL according to the TESS-2 scale had a corridor-like design, followed by a square or H-shaped design and L-shaped design. The corridor-shaped design was significantly associated with more restlessness, anxiousness and depression than the other GL as well as more hallucinations compared to the square and H-shaped GL. Subjects with dementia living in the corridor-like design also developed more loss of identity and lack of vitality during the 12 month follow up compared to the other units.

A large communication area was associated with less disorientation and less "lack of activity". A very homelike GL was associated with higher restlessness compared to GL judged as moderately homelike.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

Discussion: The individual's competence, defined as the capacity of cognition and perception and expressing the ability to interact with the environment, seems to be influenced by the physical environment. A design of GL that facilitates perceptual concepts without reducing communication areas is preferred that might reduce or postpone behavioural and psychological symptoms for the sake of the people with dementia and their caregivers.

S12.1

Psychotic depression in late-life

Benoit Mulsant

Centre for Addiction and Mental Health and Department of Psychiatry, University of Toronto, Toronto, Canada

Psychotic symptoms are often overlooked in late-life depression and can result in inadequate pharmacotherapy and poorer outcome. These symptoms provide a challenge in the management of major depression in late life. In view of the most recent published evidence, this presentation will review what constitutes adequate diagnosis and treatment of psychotic depression in the elderly.

S12.2

Psychosis in dementia

Zahinoor Ismail

Centre for Addiction and Mental Health and Department of Psychiatry, University of Toronto, Toronto, Canada

Psychotic symptoms in dementia are common and important to address. Recent evidence has increased the focus on pharmacological management of late-life psychosis. This symposium will review the risk-benefit analysis for the use of antipsychotic medications in dementia and look toward future treatments as well.

S12.3

Schizophrenia in late-life

Tarek Rajji

Centre for Addiction and Mental Health and Department of Psychiatry, University of Toronto, Toronto, Canada

In addition to medical comorbidity, late-life schizophrenia provides treatment challenges due to ongoing cognitive and psychosocial deficits. This presentation will review these cognitive and psychosocial deficits and focus on cognitive behavioural social skills training in the management of schizophrenia in late life.

S13.1

Neuroimaging and genetic findings in late-life depression

An American Association for Geriatric Psychiatry (AAGP) Symposium

Jeffrey Lyness[1]; David Steffens[2]

[1]*University of Rochester Medical Center, Rochester, NY, United States;* [2]*Duke University Medical Center, Durham, NC, United States*

A number of neuroimaging and genetic findings in late life depression have recently been reported. This presentation will review recent structural and functional imaging findings in geriatric depression. In addition, new data on candidate genes related to monoamine metabolism, vascular risk, and folate metabolism will be presented.

S13.2

Strategies to deal with depression in nursing homes

An American Association for Geriatric Psychiatry (AAGP) Symposium

John Snowdon

University of Sydney, Sydney, ACT, Australia

An interplay of various factors can result in nursing home residents becoming depressed. Identifying and then properly assessing the range of nursing home presentations of depression will allow appropriate management to be initiated.

S13.3

Strategies and challenges of implementing evidence-based practices in community-based settings

An American Association for Geriatric Psychiatry (AAGP) Symposium

Martha Bruce

Weill Cornell Medical College, White Plains, NY, United States

I will review an intervention that has modified the Primary Care model of Depression Care management to fit the practice and organization of home healthcare. The "Depression CAREPATH" intervention is being implemented and tested in five agencies located in Miami, Oklahoma, Detroit, Vermont and the Bronx. Implementation challenges addressed in this work include different clinical

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

management systems, different experience with clinical guidelines, rural vs. urban populations, language and ethnicity, and other factors.

S13.4

Strategies for depression prevention in old age

An American Association for Geriatric Psychiatry (AAGP) Symposium

Charles Reynolds

Western Psychiatric Institute and Clinic, Pittsburgh, PA, United States

I will talk about strategies for preventing depression in later life across the continuum of (1) delaying or preventing incident episodes of major depression (indicated preventive intervention), (2) preventing incomplete response to treatment of index episodes (secondary prevention), and (3) preventing associated bad outcomes, e.g., recurrence of major depression, progression of cognitive impairment, disability, and suicide (tertiary prevention).

S14.1

Service Delivery Task Force Symposium: Hot topics from around the world

Susan Mary Benbow[1]; Greg Swanwick[2]

[1]*Staffordshire University, United Kingdom;* [2]*AMNCH, Ireland*

The IPA has a Service Delivery Task Force which has recently come under the co-chairs Greg Swanwick and Susan Mary Benbow. Two initial aims have been proposed for the Task Force: 1. To share models of service delivery from around the world. 2. To learn from the experience of colleagues in other countries about which models of service delivery have worked well.

This symposium will involve colleagues from different countries presenting posters on service delivery in their country in the session which participants will be given time to study. There are confirmed participants from Africa, Asia, Australasia, Europe, the Middle East, North America, and South America.

The poster presenters will then speak briefly on hot topics in the delivery of services to older people with mental health problems in their own country and how they would like an IPA Service Delivery Task Force to help them.

The symposium will conclude with discussion on these two points facilitated by the co-chairs.

The aims of the symposium are: 1. To share learning about service delivery from different countries. 2. To develop an action plan for the IPA Service Delivery Task Force. 3. To invite interested participants to join the Task Force.

S15.1

Needs in early onset dementia: A qualitative case analysis

Raymond Koopmans[1]; Christian Bakker[1]; Marjolein de Vugt[2]; Frans Verhey[2]; Myrra Vernooij-Dassen[1]

[1]*Radboud University Nijmegen, Medical Centre, Nijmegen, Netherlands;* [2]*Maastricht University Medical Center, Maastricht, Netherlands*

Background and aims: The literature suggests that early onset dementia (EOD) leads to specific age related needs and that EOD has a higher impact on patients and their informal caregivers than late onset dementia (LOD). Indications exist that it takes longer to establish a diagnosis of dementia in EOD patients and that patients with EOD have higher prevalences of neuropsychiatric symptoms than patients with LOD. Furthermore, there seems to be a lack of specialized health care services for EOD patients. Until now, most of the research on needs and services for dementia patients and their caregivers has been focused on LOD patients.

This case study is part of the Needs in Young onset Dementia (NeedYD) study. The objectives of the NeedYD-study are to study the course of dementia and the prevalence and predictors (i.e. disease related predictors or environmental correlates) of neuropsychiatric symptoms in young onset dementia patients and to compare these figures with late onset dementia patients. A further objective of the study is to gain insight into the specific needs of young onset dementia patients and their primary caregivers.

Methods: A typical case was selected from the in total 200 included cases in the NeedYD-study. Data were obtained at time of inclusion and after six and twelve months using both semi-structured interviews with the patient's wife and quantitative assessment-instruments (i.e. Quality of Life Assessment in Dementia, Neuropsychiatric Inventory, Caregiver Management Strategy Questionnaire, Short Sense of Competence Questionnaire and Camberwell Assessment of Needs for the Elderly). Data were collected over a period of one year in order to explore over time how the primary caregiver perceived problems met, experienced transitions in care and whether needs of both patient and caregiver were met.

The audiotapes of the interviews were fully transcribed. A constant comparative analysis

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

(Corbin and Strauss, 1990) was used to identify major themes concerning problems met, perceived needs of both the patient and his primary caregiver and experiences with health services. Quantitative data were used to describe over time quality of life as perceived by the caregiver, the course of neuropsychiatric symptoms, changes in caregiver management strategy, caregiver's competence in dealing with the burden of caregiving for a dementia patient and met or unmet needs during the course of the dementia.

Results: The narratives were examined using the analytical framework of the experiences of a primary caregiver living with an early onset dementia patient and dealing with the changes following the progression of her husband's illness. Major themes were identified from the narratives concerning caregiver role and caregiver strategy, characteristics of support services, the process of adapting to long term care for a young dementia patient and quality of the relationship between the patient and his wife. The fit between services and needs during the course of the dementia suggests to be associated with perceived quality of life in both patient and his primary caregiver. Furthermore the occurrence and severity of neuropsychiatric symptoms and institutionalization of the patient seem to be associated with caregivers' competence in dealing with the burden of caregiving and whether needs of patient and caregiver could be met by health services in this case. These results will be presented more extensively during the oral presentation.

Conclusion: This single case produced a lot of data concerning needs in young onset dementia. This case confirms that the data being collected in the NeedYD-study will provide us with important knowledge about the needs of young onset dementia patients and their caregivers. We expect this study will have important implications for services in dementia healthcare.

S15.2

A French national reference centre for patients with early onset Alzheimer's disease

Sandra Wiederkehr[1]; Didier Hannequin[2]; Bruno Dubois[3]; Florence Pasquier[1]

[1]*Memory Centre, Lille University Hospital, Lille, France;* [2]*Memory Clinic, University Hospital, Rouen, France;* [3]*Memory Clinic, Hôpital Pitié-Salpétrière, Paris, France*

The French Alzheimer's disease (AD) programme 2008–2012 allowed a particular measure for young patients with AD. The prevalence of early onset AD is not well known. However, according to the medical insurance, about 8000 patients of less than 60 years of age are diagnosed with AD in France. Amongst them 1 to 2% may have a monogenic form of the disease with autosomal dominant transmission. Specific problems are met in young patients with dementia: the diagnosis is often delayed, because AD is widely considered as a disease of old age; misdiagnosis with psychiatric diseases is frequent, rare causes of dementia occurring before 60 are missed; difficult professional, family (including heredity), and social problems are encountered; relatives have to be especially supported; and most structures are inadequate to welcome these young patients. Thus, the aim of this national reference centre for young patients with AD (and related disorders) is to improve the diagnosis (including the delay), and the management of these patients and their family. This centre has written and spread out guidelines for all professionals concerned by young out- and in-patients, to be implicated in national and international networks of associations and institutions and research programmes (epidemiologic, basic, genetic, as well as clinical). A survey of these young patients is ongoing that will help to set clinical and pharmaceutical studies. We will present preliminary figures of this survey. Furthermore, an emphasis is put on training for all medical and social professionals.

S15.3

What is the burden of younger onset dementia in Australia?

Adrienne Whithall[1]; Brian Draper[2]

[1]*University of New South Wales, Coogee, NSW, Australia;* [2]*Prince of Wales Hospital, Randwick, NSW, Australia*

Objectives: Dementia can occur at any age. Dementia in younger people (onset <65 years) is unexpected, distressing and can have psychosocial and financial consequences for the patient and family. Less common than late onset dementia, it is associated with qualitatively different issues. Younger patients with dementia have very different needs from people with the late onset form and do not fit in with mainstream dementia services geared toward the elderly population. Anecdotally, the diagnosis of younger onset dementia is distressing for the person and his or her family. Dementia in younger people is a serious medical and social issue, however there is little research about this group.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

Methods: We investigated the prevalence of younger onset dementia in an Eastern Sydney catchment area. We used a case-finding survey and followed the methodology of Harvey's UK study to enable the direct comparison of rates. Following the survey, medical files were checked for case validation and patients and their carers approached for a face to face interview.
Results: Very few studies, including one pilot by our group in Australia, have investigated the epidemiology of younger onset dementia. Rates reported are variable (55/100,000 in the UK and 85/100,000 in Australia) and warrant further investigation. Carers for people with younger onset dementia report high levels of distress and burden, which is made worse by the lack of age-appropriate services. People with YOD have high rates of behavioural disturbance and this can be the presenting symptom. BPSD contributes to stress and burden experienced by carers.
Conclusion: Planning how best to help people with YOD and their families is hampered by lack of prevalence estimates, poor understanding of burden and lack of information regarding pathways to care, service use and needs. Research needs to be performed that targets these areas.

S15.4

Survival and causes of death in nursing home patients with early onset dementia

Ans Mulders[2]; Leonieke Palmen[1]

[2]SVVE de Archipel, Eindhoven, Netherlands; [1]Radboud University Nijmegen, Medical Centre, Nijmegen, Netherlands

Introduction: Early onset dementia (EOD) is associated with decreased life expectancy. Survival data obtained from groups of dementia patients including both Late Onset Dementia (LOD) and EOD patients suggest longer survival in EOD than in LOD.
Objectives: To report causes of death and to estimate survival and determinants of survival such as age at onset, gender, type of dementia in nursing home patients with EOD.
Design: 185 nursing home patients with EOD were included in this study. At inclusion data on patient characteristics, type of dementia and comorbidity were collected. After a mean follow up of 31 months data were collected from all patients that had died during the follow up period. The causes of death as reported on the death certificate were registered.
Results: 16 patients were lost to follow up. Of the remaining 169 EOD patients 71 patients had died. Mean disease duration between time of diagnosis and death was 9.93 years (1.55–14.98 years). Men survived less longer (8.9 years) than women (10.5 years, $p < 0.05$). Age at onset was significantly associated with longer survival: mean survival after diagnosis was 15.3 years in the group with onset between 31 and 40 years of age; at onset between 61 and 70 mean survival was 7.7 years ($p < 0.05$). No significant differences in survival were found between patients with Alzheimer's disease, vascular dementia, frontotemporal dementia or alcohol related dementia.

The most common primary cause of death was cachexia and/or dehydration (in 41%) followed by pneumonia (29%). Cardiovascular disease accounted for 12% of deaths, while malignancies was the cause in only 2.7%. Dementia was reported as a cause of death in 90% of the death certificates; in 5% this was reported to be the primary cause, in 15% it was reported as secondary cause, and in 69% of death certificates it was stated that the dementia was 'contributing to the cause of death.'
Conclusion and discussion: Although survival in EOD is significantly longer than in LOD, EOD results in a more dramatic reduction of life-expectancy. Female gender and younger age at onset predicted longer disease duration. Type dementia was not significantly associated with life-expectancy. Reports of the cause of death may underestimate the relevance of dementia as a cause of death in younger age groups. Special care and guidance of patients and their family members on this issue should be provided, starting at diagnosis, so they can adequately anticipate on this perspective and the patient can still formulate advanced directives about his or her future.

S16.1

Improving the diagnosis and treatment of Alzheimer's disease throughout the world

Anne Margriet Pot

Netherlands Institute of Mental Health and Addiction, Utrecht, Netherlands

In the last years, several surveys among consumers of dementia care and their health care professionals have been carried out, clarifying the problems they experience. The nature of these problems shows that there is little agreement on diagnosis and treatment of dementia in various regions of the world, and several barriers to dementia care. A common concern is cost containment, dealt with in different ways by different political and cultural systems. Access to care is expected to become more

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

restrictive. The conclusion can be drawn that only a well-coordinated public policy initiative could impact the system.

Therefore, Alzheimer Disease International (ADI) and the International Psychogeriatric Association (IPA) decided to collaborate on a public policy initiative to improve the diagnosis and treatment of AD throughout the world. For the IPA, this initiative embroiders on the focus group approach.

The public policy initiative will be aimed at:

- Bringing together consumers and providers in different regions of the world
- Jointly collecting information relevant to a specific area
- Establishing, adapting and disseminating best practices
- Influencing decision makers to implement the established best practices

In this presentation the project will be introduced. The so-called 'breakthrough method' will be used to help countries to close the gap between what we know and what is done regarding the diagnosis and treatment of dementia. A structure will be created in which participants can easily learn from each other and from recognized experts in topic areas where they want to make improvements.

S16.2

From anecdote to evidence: Promoting best practices in stigma reduction: Representing the World Psychiatric Association Scientific Section on Stigma and Mental Disorders

Heather Stuart

Queen's University, Kingston, ON, Canada

This presentation discusses the importance of building evidence in support of anti-stigma programming in the current climate of evidence-based care and several key challenges faced by researchers in the field. Anti-stigma interventions are approached broadly from public health perspective that emphasizes the burden associated with mental illness and the importance of population-based approaches designed to promote health and reduce disability. The multi-faceted nature of stigma, the overall complexity of many anti-stigma interventions, and their evolving nature, make them difficult to evaluate. Basing evaluations on explicitly defined theories of program change can help to focus attention on indicators that can be logically linked to program activities and extend knowledge about how and why a program works.

S16.3

The reduction of stigma and discrimination: A review of the literature

Carlos Augusto de Mendonça Lima

Centro Hospitalar do Alto Ave, Guimarães, Portugal

Older persons with mental disorders may be victim of a double stigma: one attached to mental disorders in general and other related to the end of life in particular. Both may difficult the access to their necessary care. According to WHO (1), stigma reduction is related to educational interventions while discrimination reduction concerns justice. The need to reduce both stigma and discrimination is ethically mandated by their harmful consequences including perpetuation and worsening of mental illness. There is no reason to exclude old people of their necessary care because of their old age or of any mental incapacity (including dementia). And the lack of resources should not justify any kind of exclusion of older people with mental illness from the care and social system. In 2003 representatives of several organizations published a consensus statement on this matter (1). Five years later a survey was conducted using several international journals focusing on mental health in old age to identify articles published on projects to reduce somehow this stigma. Results are here presented.

Reference

1. Graham, N and al. Reducing stigma and discrimination against older people with mental disorders: a technical consensus statement. *International Journal of Geriatric Psychiatry*; 2003; 18:670–678."

S16.4

Swindle and fraud of people with dementia: How associations can help representing Alzheimer's Disease International

Marc Wortmann

Alzheimer's Disease International, London, United Kingdom

Background: There are few research data about numbers, but Alzheimer's associations are often consulted about financial abuse of people with dementia. What happens quite often is that relatives find out that their father or mother got married, without them knowing. Other issues are signing

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

contracts without understanding, problems with establishing a will or proxy.

How Alzheimer's associations can help: Associations have found various ways to support, by providing information to carers and families about risks, guardianship and advance directives. There is practical support in case of marriages, for instance with marriage contracts and different types of guardianship. Examples from several countries will be discussed as well as some cases.

On another level, associations have lobbied for better legal protection for people with dementia. There are good examples from several European countries and Australia.

How researchers can help: We need more data to convince policy makers to improve protection of frail elderly. Available data will be discussed as well as recommendations for further action.

S17.1

Self neglect: A challenge for physicians

James O'Brien

University of Louisville, Louisville, KY United States

Self neglect may in fact be the most common type of neglect that is reported to Adult Protective Service Agencies and perhaps the most frustrating to deal with. Physicians by and large have tended to both under report and not manage this problem very effectively. Many of the self neglecting individuals suffer from cognitive impairment either as a result of dementing illnesses, substance abuse, or alcoholism. A subgroup does exist that shows no clear cut evidence of cognitive impairment, neither are they victims of alcoholism or drug abuse. It is these individuals that perhaps are most difficult to manage. A case will be presented to expose the management challenges in maintaining a balance between autonomy and paternalism.

S17.2

Promoting promising approaches to abuse prevention in long-term institutional care settings

Elizabeth Podnieks

Ryerson University, Canada

Canadian researchers have been increasingly generating a body of knowledge about promising practices to address abuse and neglect of older adults living in the community. There is far less scholarly activity exploring similar practices in long-term care (LTC) settings. Victims of abuse and neglect in LTC may suffer loss of dignity and personhood, physical trauma, and even early death. The health care system faces extra economic costs related to health care interventions and lost productivity. And, more broadly, public confidence in LTC institutions is compromised.

This presentation will describe a national project which aims to increase the capacity of community, institutional and government stakeholders across Canada to better understand and respond to the complex issue of abuse and neglect in the range of LTC facilities providing care and support. This presentation will provide a brief overview of the project's first activity (an analysis of Canadian laws, policies, regulations, and standards currently used to prevent and address abuse and neglect of residents in LTC), as well as the project's second activity (holding five regional forums across Canada with stakeholders representing government, long-term care institutions, care providers, advocacy groups, and law enforcement agencies), and a discussion of the findings and key recommendations.

S17.3

Safeguarding vulnerable adults in the 21st century: Solidifying social policy in the UK

Paul Kingston

Staffordshire University, United Kingdom

Over the last 20 years, the UK has developed a complex ecology of strategies, mainly welfarist in nature, to protect vulnerable adults. More recently, government has decided to solidify our ability to protect vulnerable adults with additional legislation to support the advisory code of conduct launched in 2003 'No Secret.' This presentation will outline two new legislative codes: The 'Safeguarding Vulnerable Groups Bill 2006,' and the Adult Support and Protection (Scotland) Act 2007, recently ratified by the UK Parliaments.

S17.4

Elder abuse: Connections between shame, power, and self-esteem

Toshio Tatara[1]; C Erlingsson[2]

[1]*Shukutoku University, Japan;* [2]*Kalmar, Sweden*

One of the most common assertions concerning elder abuse is that elder abuse is connected with experiencing shame. Although this idea appeals

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

to a common sense understanding, it is very poorly substantiated in elder abuse research. Based on recent Swedish research on elder abuse risk indicators and perceptions of elder abuse, the significance of shame experiences in elder abuse situations will be discussed, and links between shame and the related issues of power and self-esteem will be explored as well.

S18.1

Rescue pharmacotherapy with a SNRI after SSRI treatment failure

Ellen Whyte

University of Pittsburgh, Pittsburgh, PA, United States

Objective: To estimate the efficacy of switching to a SNRI after SSRI failure in older depressed subjects.
Method: Forty older subjects with major depressive disorder (DSM-IV) who either failed or could not tolerate escitalopram mean (SD) maximum dose of 18.3 (3.8) mg/d were treated openly with duloxetine mean (SD) maximum dose 93.0 (27.8) mg/d.
Results: Twenty subjects responded to duloxetine, defined as a Hamilton Depression Rating Scale score of = < 10 for 3 consecutive weeks. The median time to response was 12.0 weeks (95% CI: 8.4–14.6 weeks).
Conclusion: Our preliminary data suggests that duloxetine (up to 120mg/d) is a well tolerated and effective treatment for older adults who fail initial treatment with a SSRI.

S18.2

Pilot study of augmentation with aripiprazole for incomplete response in late-life depression: Getting to remission

Charles Reynolds; Meera Sheffrin

University of Pittsburgh, Pittsburgh, PA, United States

Objective: To determine the feasibility and safety of aripipazole augmentation for incomplete response to sequential SSRI pharmacotherapy in late-life depression.
Method: A 12 week, open-label, pilot study of 24 patients with major depressive disorder (DSM-IV) who responded partially or not at all to a six week trial of escitalopram, followed by either duloxetine or venlafaxine. Subjects received 2.5–15 mg/day of adjunctive aripiprazole for 12 weeks.
Results: 19 subjects completed the 12 weeks of augmentation, 12 of 24 patients met criteria for remission and 2 discontinued due to side effects.
Conclusion: In older adults with incomplete response to SSRI and SNRI pharmacotherapy, aripiprazole was well tolerated and symptoms of depression improved significantly during treatment with aripiprazole.

S18.3

A randomized, single-blind, comparison of venlafaxine with paroxetine in elderly patients suffering from resistant depression

Doron Mazeh

Abarbanel Mental Health Center, Bat Yam, Israel

Background: It is estimated that up to 45% of patients with depression do not have an adequate response to a first trial of antidepressant therapy with even higher reported rates for the elderly.
Aim: To compare the efficacy and the tolerability of venlafaxine versus paroxetine in elderly patients suffering from resistant major depression who did not respond to at least two previous adequate trials of antidepressants.
Method: Patients entered an 8-week single-blind study. Patients were rated using the Clinical Global Impression Scale (CGI), Hamilton Rating Scale for Depression (HAM-D) and the Geriatric Depression Scale (GDS). Assessments were performed at baseline and on days 7, 14, 21, 28, 42, and 56. Side effects were recorded in a systemic manner.
Results: Thirty patients were included in the study (17 women, 13 men; mean age = 75.9 years, range: 68–83), and all had completed the six-week trial. Mean dose of venlafaxine used was 165 mg/day (SD = 73.8; range 75–300 mg). Mean dose of paroxetine used was 26 mg/day (SD = 15.04; range 10–60 mg). Nine patients treated with venlafaxine (60%) and 5 patients treated with paroxetine (33%) remitted after eight weeks of treatment. Four patients treated with venlafaxine and 8 patients treated with paroxetine failed to respond. Significant improvement in HAM-D rating scores between baseline and endpoint were observed in both groups of patients. The mean HAM-D change for paroxetine was –12.5 and for venlafaxine –19.1 ($p<0.05$). The mean GDS change for paroxetine was –3.2 and for venlafaxine –6.0 ($p<0.3$). The mean CGI change was –2.3 for paroxetine and –3.5 for venlafaxine ($p<0.05$). Venlafaxine was significantly superior to paroxetine on CGI and HAM-D measures. Side-effects were transient and did not differ between treatment groups.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

Conclusion: Elderly depressed patients resistant to previous treatments had responded to a trial of paroxetine or venlafaxine. Remission rates were higher for venlafaxine and tolerability was acceptable for both compounds.

S18.4

Lithium augmentation compared with phenelzine in treatment-resistant depression in the elderly: A single-blind, randomized-controlled trial

Rob Kok

Parnassia Psychiatric Institute, The Hague, Netherlands

Aim: To compare two treatment options in patients with major depression who do not respond to an SSRI and a TCA, according to the Dutch Multidisciplinary Depression Guideline.
Method: Twenty-nine elderly inpatients with major depressive disorder according to DSM-IV who had previously failed to respond to one or more adequate trials with a tricyclic antidepressant or venlafaxine were included in a 6-week, single blind, randomized controlled study with a 2 year follow up. Subjects received either lithium augmentation or a switch to the MAO-inhibitor phenelzine. The primary outcome criterion was remission, defined as a final score of $\leq$10 on the Montgomery-Åsberg Depression Rating Scale. Response was defined as at least 50% reduction on the MADRS or the Hamilton Depression Rating Scale (HAM-D).
Results: Twenty-eight subjects completed the trial. Remission on the MADRS was achieved by 33.3% of the lithium patients, compared with none of the phenelzine patients ($p = 0.042$). Response also showed a difference in favor of lithium augmentation ($p = 0.035$ on both the MADRS and the HAM-D). Overall tolerability was good, with no dropouts due to side effects. Subjective memory impairment was more prevalent among patients receiving phenelzine ($p = .002$), and tremors were significantly more prevalent among patients receiving lithium ($p = .002$). During the two year follow up, 25 patients (86.2%) did achieve remission, particularly on prolonging the lithium treatment (5 patients) or on lithium augmentation to phenelzine (5 patients).
Conclusion: Lithium was more effective than phenelzine in elderly patients with treatment-resistant major depression, while tolerance of both treatments was remarkably good in this group of elderly inpatients with many comorbid medical disorders.

S19

Testamentary capacity and undue influence: International controversies

Panelists:
Sanford Finkel Chair[1]; Kenneth Shulman[2]; Horacio Firmino[3]; Carmelle Peisah[4]; Barry Reisberg[5]

[1]*University of Chicago, Chicago, IL, United States;* [2]*University of Toronto, Toronto, ON, Canada;* [3]*Coimbra University Hospitals, Coimbra, Portugal;* [4]*University of New South Wales, NSW, Australia;* [5]*New York University School of Medicine, New York, NY, United States*

This panel discussion will focus on perspectives of different nations and cultures, as it applies to testamentary capacity and undue influence. The presentation is organized by the IPA Task Force on Testamentary Capacity and Undue Influence. An international panel will discuss and debate a range of issues, including:

1 "Family members should always be left something."
2 What are reasonable guidelines regarding knowledge of the nature and extent of property?
3 Is undue influence limited to coercion? If not, what are the gradations?
4 What is the role of measurements and scales in contemporaneous assessment? What is the role of orientation? When is a formal neuropsychological evaluation indicated?
5 When should a signing of a will be videotaped, and how should the procedure be accomplished?
6 When, if ever, is a deathbed will appropriate?
7 Can the concept of staging of dementia be applied retrospectively to contested wills?
8 To what extent and how does the clinician assessor determine the appropriate role of family during a contemporaneous review at the time of (or just before) the execution of a new will?

There will be time for questions and input from the audience.

S20.1

Education in old age psychiatry in Europe

Horacio Firmino[1]; Lia Fernandes[2]; Constança Paúl[3]

[1]*Coimbra University Hospital, Coimbra, Portugal;* [2]*Hospital S. João, Oporto, Portugal;* [3]*University of Oporto, Oporto, Portugal*

a) Facts and new developments: Old Age Psychiatry is a branch of psychiatry and forms part of the multidisciplinary delivery of mental

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

health care to older people. The specialty of psychiatry of the elderly requires a grounding in general psychiatry and in general medicine as well as training in the specific aspects of both psychiatric and medical conditions as they occur in older people. Psychiatry of the elderly should be taught in the variety of settings in which it is practised. Training in mental health care of older people should be offered at both undergraduate and postgraduate level and also during continuing professional development. It is important to recognise that in some countries, resources, especially in terms of mental health professionals, are very limited. In these countries it will be necessary to establish sensible priorities for mental health problems of the elderly. In this presentation we consider some ideas to develop educational training in European Countries.

b) Postgraduate Training for Mental Health Professionals: Training in psychogeriatrics is crucial for all healthcare professionals who provide care whether their background is psychiatry, psychology, social work, nursing or others. Specifically, it is important to develop training programs, namely in postgraduate levels, and to establish centers of excellence to advance research and clinical care in late-life mental disorders. In this context, psychiatric education integrated in a comprehensive and multidisciplinary PhD program, like the recent project in Oporto University, will be a major achievement. It will certainly contribute to the research training of graduate students coming from different backgrounds and contributing as to the depth of studies as to the depth of the interdisciplinary exchanges of senior staff. It should be realized that in the field of gerontology there are not many examples with the same potential in Europe. This kind of program with an international participation, will certainly contribute to the advancement of geriatrics in Portugal and in an international context.

S20.2

Geriatric psychiatry in Canada: On a pathway to subspecialization

Melissa Andrew[1]; Catherine Shea[2]

[1]*Queen's University, Kingston, ON, Canada;* [2]*Royal Ottawa Mental Health Centre, Ottawa, ON, Canada*

While Geriatric Psychiatry has officially been recognized as a distinct subspecialty in many countries worldwide, prior to 2009 Canada has not recognized any distinct Psychiatric subspecialties. The Canadian Academy of Geriatric Psychiatry (CAGP) has promoted advancements in systems of care, research and advocacy for seniors, and has particularly supported educational development for physicians at all stages of training, and other health care providers. Subspecialty status would provide further support for these activities within Canada, and facilitate alignment with international colleagues. In this presentation we present a rationale for subspecialization, and a training model submitted for consideration by the Royal College of Physicians and Surgeons of Canada. This model reflects the unique educational requirements necessary for psychiatric care of the elderly, including augmented general medicine training, development of expertise with families and caregivers, and the need for excellent teaching skills for diverse audiences. We will outline anticipated barriers to implementation of the model, and suggest strategies to address these challenges.

S20.3

Pikes Peak model for training in professional geropsychology

Bob Knight

University of Southern California, Los Angeles, CA, United States

In 2006, professional geropsychologists gathered to develop a training model to help guide the development of training programs in the U.S. for psychologists planning to work more extensively with older adults. The conference developed a set of aspirational competencies covering attitudes, knowledge, and skills for entry level work with older adult populations. Key themes of this Pikes Peak model will be described as well as exemplars of training paths for acquiring the competencies across doctoral programs, internships, and postdoctoral fellowships. Devising training resources for licensed psychologists who transition into working with older adults is a major challenge for the future.

S20.4

Training mental health professionals to work with older adults: Barriers, challenges and opportunities

Nancy Pachana

University of Queensland, Brisbane, QLD, Australia

The percentage of persons over age 65 is increasing worldwide, yet the numbers of health professionals trained specifically in geriatrics is declining. This is particularly true of many mental health disciplines but appears most acutely in clinical psychology. The mental health professions have taken a varied

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response to training both students and retraining professionals to work with older adults. The professions must address the challenges posed by this situation, and recognise creative opportunities to increase capacity for work with older populations. International data on addressing attitudes towards older adults as a barrier to training are reviewed, along with protocols and programs designed to break down such barriers. Pilot programs to encourage training in clinical psychology as well as multidisciplinary initiatives from Australia are reviewed. Suggestions for stimulating interest and fostering positive attitudes towards older adults as well as increasing and improving career paths and expanding into under-served areas (e.g. rural settings, long term care) are discussed.

S21.1

An empirical review of psychotherapy outcome for late life depression

Ken Laidlaw

School of Health in Social Science, Scotland

This paper provides an up to date review of psychotherapy outcome data for late life depression. The author draws upon data relating to individual randomized controlled trials, and recent meta-analyses as well as systematic reviews to provide a summary of the information that can be determined as to the outcome of psychotherapy for late life depression. In discussing the evidence there is an emphasis upon cognitive-behavioral therapy as this has the most systematic evidence base. Emergent evidence relating to psychotherapy for depression comorbid with physical illnesses will also be noted. The author will also provide a glimpse into possible future directions for psychotherapy with older people.

S21.2

"Alliance" and the role of the therapeutic relationship in geriatric psychotherapy

Joel Sadavoy

Mount Sinai Hospital, Canada

While techniques of effective psychogeriatric psychotherapy vary, one core element of successful treatment appears to be universal, the therapeutic alliance between patient and therapist. The core elements of the alliance include: 1) shared goals for the therapy between patient and therapist, 2) shared perception of the tasks that need to be addressed and 3) an intangible element, the shared bond or feeling of comfort between patient and therapist, that is, the mutual understanding that the therapist understands, and that the alliance is strong enough for expression of frustration, disappointment or hopelessness by the patient. Formation of this intangible but crucial relationship in therapy is challenged by factors relatively specific to treatment of elders including: ageist or prejudicial ideas about aging harboured, sometimes unconsciously, by both the therapist and patient; stereotypic views of aging including issues of death, decline or illness; the masking by age and appearance of inner states of emotion, identity, conflicts and self image of the patient; the frequent multifaceted complexity and duration of the patient's problem set, life and emotional experience; the age difference common between therapist and older patient; the unfamiliarity of psychotherapy to the current cohort of elders; frequent feelings of shame at asking for help; assaults to the patient and therapist's sense of hope and optimism in therapy; undue focus on physical issues and somatization of emotional issues. This presentation will explore the evidence for the importance of the alliance, the different challenges posed in psychogeriatric populations and strategies for understanding and enhancing the alliance.

S21.3

Applying gerontology to psychotherapy with older adults

Bob Knight

USC Davis School & Ethel Percy Andrus Gerontology Center, United States

Research in gerontology provides an empirical basis for understanding the realities of aging and so contradicts negative thoughts about aging held by older adults themselves. Gerontology can also provide an empirical basis for helping older adults form a realistic life span self construct that supports a more positive self concept. These approaches can be used with depressed older adults and also to support the development of wisdom in older adults as a preventive approach.

S21.4

Mark D. Miller

Western Psychiatric Institute and Clinic, Pittsburgh, PA, United States

Using interpersonal psychotherapy for cognitively impaired elders and their caregivers

Cognitive impairment, particularly executive dysfunction, is often misrecognized or misunderstood

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

by caregivers in its early stages and can lead to interpersonal disputes or even elder abuse. Interpersonal Psychotherapy (IPT) has recently been adapted for specifically meeting the needs of both cognitively impaired patients and caregivers, recently published in book form (Clinicians Guide to Interpersonal Psychotherapy in Late Life, Oxford, 2009). This presentation will outline the principles of IPT-ci for use in patients with or without depression and present video vignettes to illustrate key features. Providing flexibly scheduled individual or joint sessions with patients and caregivers, role dispute resolution and seeking "steady state" with lifelong management strategies will be outlined. This new adaptation is particularly well suited for training social workers to interface with geriatric patients in primary care settings.

S22.1

Primary prevention of dementia: A review of current trials, methodological issues and perspectives

Sandrine Andrieu

Toulouse University Hospitals, Toulouse, France

Prevention of neurodegenerative disease, such as Alzheimer's disease (AD), is a growing public health problem and several potential factors (lifestyle, cognitive stimulation and preventive drugs) have been identified in large observational studies. In order to demonstrate the real effectiveness of these factors randomized controlled trials (RCTs) are needed but few RCTs were developed in the past and first results have so far been generally conflicting with those of epidemiological studies. This lack of effect may have been due to the inefficacy of the interventions tested, but methodological factors probably also played a part (intensity of exposure, critical period of exposure). Such trials raise specific methods because they require large numbers of subjects and lengthy follow-up periods. We will present a systematic review of RCTs for the primary prevention of neurodegenerative dementia or cognitive decline. Trials involving only patients with dementia or some specific cognitive impairment were excluded from this review. The results of this systematic review and the methodological issues raised (target population, methods of recruitment, clinical relevance of endpoints, follow-up period) will be presented and discussed. In conclusions, the methodology of primary prevention RCTs for neurodegenerative dementia is of great importance. Dementia prevention trials have so far mainly targeted pharmacological intervention strategies (hormone replacement therapy in women, antioxidants and anti-inflammatory agents) and several of these trials were terminated prematurely due to safety concerns. Some public health initiatives promoting physical exercise and a healthy diet have shown positive results and proved that it is possible to change lifestyle habits, even in elderly persons, so it will be important in future RCT to also evaluate lifestyle interventions which combined different preventive approaches (nutrition and physical exercise). For risk factors that play a role early on in the life course, public health interventions at the population level, rather than RCTs, should be discussed as alternative methods in order to assess protective effect of theses factors.

S22.2

The beneficial effects of cognitive training

Erika Dahlin

Umeå University, Umeå, Sweden

Cognitive training can improve performance on trained tasks as well as untrained tasks. The magnitude of gain in untrained tasks is, however, variable and often there is no transfer at all. We demonstrated transfer in young participants to a 3-back test of working memory after five weeks of training in updating. The transfer effect was based on a joint training-related activity increase for the trained and transfer tasks in a striatal region that also was recruited pre-training indicating that transfer can occur if the criterion and transfer tasks engage specific overlapping processing components and brain regions. For elderly adults, results showed training-related gains in the trained updating task of about the same magnitude as observed for young adults. Another finding was that older persons performed above the baseline level of young persons after five weeks of updating training. We found fronto-parietal increased activation following training for older adults indicating that the trained task performance was not automatized to the same extent as for the young. Further, we found increased striatal activation post training in letter-memory for older participants, although the striatum was not activated before training. These findings reflect age-related changes in the striatal dopamine system, which serves as a powerful mediator of the cognitive losses that occur during aging. To determine whether the training-related increases in striatal blood flow observed in our recent study were driven by increased release of dopamine as a function of training, PET data is now being collected. Further, data from five weeks of task-shifting training is being collected to investigate whether the finding

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

that transfer occur if the trained and untrained tasks engage overlapping processing components and brain regions were process/task specific or not. Preliminary data from the PET-study and task-shifting training study will be presented.

S22.3

Prevention of cognitive decline and dementia: Experience from the São Paulo Ageing & Health study (SPAH)

Marcia Scazufca

University of Sao Paulo, Sao Paulo, Brazil

There is increasing evidence suggesting that modifiable and preventable events across the life course play a role in the aetiology of cognitive decline and dementia later in life. The objective of this presentation is to investigate the association between indicators of socioeconomic disadvantages throughout the life-course with cognitive decline and dementia, and to explore how pathways that would act upon the passive and active cognitive reserves may explain the association of socioeconomic adversities across the life course with cognitive decline and dementia among older adults in São Paulo, Brazil. We will investigate two pathways: the exposure to more complex mental activities throughout one's life span (involved in the formation of active brain reserve), such as challenging educational and occupational activities, that may enhances the ability to endure stress and damage and also trigger a cascade of events that reduces the risk of brain damage such as healthier life styles (physical activity, lower alcohol consumption, non-smoking) and decreased risk for cardiovascular disease; and the impact of early life factors that precede formal education on passive brain reserve, during the formation of neurons in intrauterine and early neonatal developmental period. **Methods:** The Sao Paulo Ageing & Health study (SPAH) involved participants aged 65 years and older (n = 2005), living in disadvantaged areas of the city of São Paulo, Brazil. The outcome of interest was prevalent dementia at inclusion and cognitive decline and incident dementia at 2 years follow-up. Exposures included in the analyses were socioeconomic position (SEP) indicators in childhood (place of birth and literacy) and in adulthood (occupation and income), anthropometric measurements as markers of intrauterine and childhood environment (head circumference and leg length), smoking, diabetes and hypertension. Logistic regression models were used to test the hypothesized pathways. **Results:** At inclusion place of birth (rural area) and illiteracy were associated with increased prevalence of dementia. This association was partially mediated through adulthood SEP. Head circumference and leg length were also clearly associated with dementia but there was no evidence that this effect was mediated by early life socioeconomic disadvantage. We will also present how these risk factors were associated with cognitive decline and incident dementia. **Conclusions:** Early socioeconomic disadvantages seem to operate through biological mechanisms associated with passive brain reserve and opportunities in life representing active cognitive reserve. Prevention of cognitive decline and dementia should start early in life and continue through life span as seen with many other chronic diseases.

S22.4

Finnish multi-domain interventions to delay cognitive impairment

Miia Kivipelto

Karolinska Institutet, Stockholm, Sweden

The time for prompt action has come following epidemiological evidence that dementia and Alzheimer's disease (AD) share many vascular and lifestyle related risk factors with cardio/cerebrovascular diseases. We have developed the first Dementia Risk Score in the Finnish CAIDE study based on midlife risk factors. This is a brief presentation of Finnish multi-domain intervention studies meant to delay the onset of cognitive impairment and dementia. The Finnish Diabetes Prevention Study (FDPS) is a landmark RCT showing the effectiveness and applicability of dietary and physical activity interventions in general population. In 2009 the study has been extended to evaluate cognitive performance. The ongoing Dose Response to Exercise Training (DR'S EXTRA) study is a carefully designed RCT enabling detailed dose-response analyses of exercise and dietary intervention on cognition and mediating pathways. These trials provide rationale to initiate The Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER), the first multi-domain intervention study primarily designed to delay cognitive impairment among high-risk individuals. Inclusion criteria are: 1) Dementia Risk Score over 8 points, and 2) Mild memory impairment identified with CERAD test battery. Approximately 1200 subjects aged 60–75 years will be randomized to intensive intervention and regular health advice groups. The 2-year multi-domain intervention will have four main components: i) Nutritional guidance, ii) Physical activity, iii) Cognitive training and social activity, iv) Intensive monitoring and management of metabolic and vascular risk factors. Subjects in the reference group will be given general public health advice. The primary outcomes are cognitive impairment measured with Neuropsychological Test Battery,

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

dementia, and disability. The secondary outcomes include depressive symptoms, vascular risk factors and disorders, quality of life, utilization of health resources, and brain MRI measures for a sub-group of subjects. An extended follow-up is planned as a 2-year follow-up is too short to evaluate dementia incidence in this age-group.

Conclusions: The FINGER study proposes an innovative approach to delay cognitive decline and dementia while simultaneously intervening upon several risk factors of other major diseases. Earlier Finnish intervention studies have utilized two forms of intervention (dietary and exercise) with positive results regarding metabolic and vascular outcomes (analyses for cognitive outcomes ongoing). The FINGER will be the first carefully designed RCT to clarify to what extent a multi-domain intervention will delay cognitive impairment among persons with an increased dementia risk. These data are urgently needed for health education and community planning

S23.1

Hormone therapy and cognitive function: Insights into the critical window hypothesis

An American Association for Geriatric Psychiatry (AAGP) Symposium

Paul Newhouse[1]; Pauline Maki[2]

[1]*University of Vermont College of Medicine, Burlington, VT, United States;* [2]*Université de Montréal, Montréal, QC, Canada*

Cognitive complaints are common in midlife women. This presentation will provide a brief overview of the effects of menopausal hormone therapy on cognition and the brain systems sub-serving cognitive functions, particularly memory. The review will draw on findings from randomized clinical trials and functional neuroimaging studies in humans. Basic science and clinical studies have investigated the potential neuroprotective effects of estrogen. One apparent area of convergence in these studies is the benefits of estrogen on cognitive tasks mediated by the hippocampus and frontal lobes. Findings from basic science studies parallel findings from neuroimaging studies in humans and suggest that estrogen might influence cognitive tasks mediated by the hippocampus and prefrontal cortex. Neuroimaging studies show that women who initiated hormone therapy before the final menstrual period have improved verbal memory and hippocampal function later in life. These findings complement results from the Baltimore Longitudinal Study of Aging, which showed that older women who continuously used hormone therapy since early in menopause showed improved verbal memory and alterations in hippocampal and frontal lobe function. These studies support the view that early use of certain forms of hormone therapy might be beneficial for cognition and brain function. Clinical trial results suggest that certain hormone therapy regimens provide no benefit to cognitive function and can have profound negative effects, particularly when initiated later in life. Recent evidence also suggests a relationship between hot flashes and memory dysfunction, but only when hot flashes are measured objectively with ambulatory monitors. Women under-report the true number of hot flashes they have by over 40%, so previous studies may have failed to detect a relationship between memory and hot flashes because they relied on self-reported hot flashes. Despite some evidence of favorable effects of hormone therapy on cognition and brain function in some groups of women, hormone therapy is not approved for treatment of cognitive complaints or dysfunction in any patient group.

S23.2

Stress hormones and aging

An American Association for Geriatric Psychiatry (AAGP) Symposium

Sonia Lupien

University of Illinois at Chicago, Chicago, IL, United States

In the last two decades, there have been many factors studied as potential biomarkers of cognitive impairments in later life. Over the past three decades, one of the factors that received increased attention is the secretion of stress hormones. Stress hormones are liposoluble, and thus they have the capacity to cross the blood-brain barrier and access the brain, where they can influence cognitive process as well as emotional processing. In this presentation, I will summarize the results of a series of studies from my laboratory on the association between stress and aging in humans. Previous results from our group showed that cumulative exposure to high endogenous levels of the stress hormone glucocorticoid (cortisol in humans) in an older population predicts both memory impairments and a 14% reduction in hippocampal volume (Lupien *et al.*, 1994, 1998). We also have shown that aged human memory can be acutely modulated by pharmacological manipulations of gluccocorticoids (Lupien *et al.*, 2002a, 2002b), and we showed that personality factors known to be involved in the increased

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

response to stress (Pruessner *et al.*, 1997) are potent predictors of both age-related cognitive changes (Pruessner *et al.*, 2004) as well as hippocampal volume (Pruessner *et al.*, 2005). Altogether, these results suggest that stress can be a potent factor modulating cognitive performance and emotional processing in old age.

S23.3

Testosterone, memory and cognition: Complex interactions and potential risk factors for aging

An American Association for Geriatric Psychiatry (AAGP) Symposium

Monique Cherrier

University of Washington School of Medicine, Seattle, WA, United States

Natural age related declines in testosterone (T) are associated with decrements in cognitive abilities independent of health status. Low T levels over time are associated with increased risk for developing Alzheimer's disease (AD). These findings suggest that men with low T levels are most at risk for age-related cognitive decline and AD and therefore most likely to benefit from T supplementation to prevent the development of AD or age-associated cognitive decline. However, studies to date examining cognitive changes in response to testosterone supplementation have been mixed. This presentation will review the neurobiologic connection between androgens and cognitive function in animals and humans. Studies relating endogenous androgens as well as studies that manipulate androgens through deprivation or supplementation and their effects on cognition will be discussed. Studies examining androgen supplementation in mild cognitive impairment (MCI) and Alzheimer's disease (AD) patients and neuroimaging in humans will also be reviewed. Finally, the potential therapeutic benefit and adverse effects of T supplementation will be reviewed.

S23.4

Hormones, neurotransmitters, and cognitive aging: A new hypothesis

An American Association for Geriatric Psychiatry (AAGP) Symposium

Julie Dumas

University of Vermont College of Medicine, Burlington, VT, United States

Research in cognitive aging has described significant age differences on tests of attention, working memory and episodic memory. Work in cognitive psychology has focused on understanding situations where age differences occur as well as in exploring theories to explain these age differences. A parallel literature exists in cognitive geriatric psychopharmacology examining the effects of medications on age-related changes in cognition. However, much of the research in this field is not motivated by theoretical distinctions regarding age effects on cognitive processes developed in cognitive psychology. This talk will evaluate the effects of age-related gonadal steroid changes on cognition and mood and the subsequent effects of hormone treatment on cognition in older women and men in terms of existing theories from cognitive aging. Age effects on cognition may be explained by overall changes in general processes affecting all aspects of cognition like processing speed, working memory, and interference control. Modifications to these theories will be proposed to incorporate data from recent studies examining the effects of hormone and drug therapy on cognitive functioning in aging. A model will be described that incorporates theories of cognitive aging and the data from hormone treatment and neurotransmitter manipulation studies that links biological and psychological models of normal and pathologic cognitive aging. This model will have both heuristic and practical value for research in this area and clinical treatment.

S24.1

Older people with learning disability and dementia

Paul Kingston

Staffordshire University, United Kingdom

People with a learning disability (particularly Down's Syndrome) are at increased risk of developing dementia and are likely to develop dementia earlier than their peers without a learning disability. There has been growing interest in the United Kingdom in how to provide a service to this group, which is projected to increase as the population greys in the future and the life expectancy of people with learning disabilities increases. Neither learning disabilities services nor old age psychiatry services are designed to meet the needs of people with LD and dementia, with the result that they may fall between services and incur considerable disadvantage. There is concern about their access to anti-dementia drug treatments and to memory clinic services and continuing debate about whether they should use mainstream or super-specialist services.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

The Faculties of Old Age Psychiatry and Learning Disability (LD) at the Royal College of Psychiatrists have carried out a national survey of psychiatrists in the specialties of LD and OAP in order to gather information about how services are currently provided, and how they might be provided in the future.

The paper will draw on the author's involvement in the above survey, in a local initiative to identify and screen adults with Down's Syndrome and in debate about how a service is best provided for this group in a city with a multi-cultural population totaling about 250,000 people.

Conclusions: People with a LD at risk of dementia and those who have an established dementia are at risk of falling between services. A service designed around their needs would include the following components: routinely available appropriate information for service users and their families, screening to those at high risk, access to memory clinic services that use appropriate assessment and monitoring tools, psychological support services, access when appropriate to anti-dementia drug treatments and long term support with access to family carer support, social and psychological interventions. To achieve this service will involve LD services, OAP services and others (especially social services) in establishing close working relationships.

S24.2

Health and homeless older people

Older people who are homeless are in effect an "invisible" population. In the United Kingdom older people who are homeless are largely ignored by statutory health services and rarely feature on the health policymaking agenda. It is difficult to think of a person more in need of support than an older person with multiple health issues (both physical and mental) who is homeless. As in most public and private health services across the world access to support begins with a permanent address, the classification "no fixed abode" presents bureaucratic and administrative barriers to homeless older people in need of services. Lacking almost any kind of political power, resources or empowerment older homeless people are marginalised and vulnerable and are unable to make themselves heard as other more powerful groups who have political power and resources shape and determine service provision. Homelessness in older people rarely features as a topic in the literature, forms little or no element in the medical curricula, and is simply "off the radar" for most practitioners.

The problems of older homeless people are set to grow as the demographics of population ageing and the current economic worldwide recession creates difficulties for individuals, groups and services. This short presentation will:

Define homelessness for older adults
Identify the likely number of older adults who are homeless
Describe the physical and mental health problems of this vulnerable population
Identify good practice for service provision to homeless older people

Building on the work of Cohen (1999) this presentation will outline a model of homelessness and ageing. In 2008 the presenter carried out research into homelessness and health in a large city in the English Midlands. Whilst provision for younger adults was generally good there was little evidence that services even acknowledged the existence of older homeless people. For example local shelters and hostels had upper age cut off points in their admission criteria (usually 60 years) and most provision was geared to young female homeless people with small children. Of those people who were over 60 and who were sleeping rough many feared abuse and violence not only from the public but also from younger homeless people.

For many older people the term "home" means something quite different from its meaning for younger people who often see a home as a financial asset and status symbol to be traded in and replaced at regular intervals. For a great many older people a home is the bedrock and foundation of their whole life, and is a source of memories, experience and identity. To lose a home in old age is "to lose a part of oneself." This presentation will identify a range of factors including: divorce; death of spouse; military discharge; retirement; mental health problems and financial difficulties that create this marginalised and vulnerable population. Services must be developed to respond to the needs of this "invisible" group.

Cohen(1999) Ageing and Homelessness. Gerontologist, 39, 5–14.

S24.3

The mental health needs of older male prisoners in four prisons in the West Midlands UK

Since April 2006 the National Health Service (NHS) in the UK has been responsible for commissioning primary health care in state run prisons. People aged 60 and over are now the fastest growing age group in the prison estate. The number of sentenced prisoners aged 60 and over

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

rose by 149% between 1996 and 2006. Harsher sentencing practices and longer sentences are the primary contributors to this increase.

Previous research has identified high levels of mental illness amongst older prisoners. This paper describes a programme of research commissioned by South Staffordshire Primary Care Trust to measure the range of mental health problems experienced by prisoners aged 50+ in four male prisons in the West Midlands, UK. The research was conducted in 2008/9 and explored the prevalence of mental illness amongst older inmates and the effectiveness of current service provisions.

Invitations were sent to all eligible prisoners in the participating prisons. Estimates of morbidity were obtained by face-to-face interview using the Geriatric Mental State Schedule; the Mini Mental State Exam and the Short Form 12 Health Survey. Data on previous health needs and care received in prison were obtained from prisoners' records. Qualitative data on the experience of health needs and of receiving healthcare was obtained in the course of the interviews with prisoners, and by face to face interviews with prison staff.

Interviews were conducted with 121 prisoners. 35% showed evidence of depressive illness; 12% showed evidence of anxiety; and 6% problems of cognition. Just over half were convicted of sex offences and 20% of violent crimes including murder. A third had no previous convictions of any kind, and just under half had never been in prison before.

Some respondents had achieved old age while in prison. Others had entered prison late in life. Many had lost family connections on sentence. A third were serving life sentences and a quarter sentences of 10 years or more. Most of these expected to be released on license requiring some form of supervision, and many of these expected to live away from their home environment. Many men expressed anxiety at the prospect of release.

Few provisions for prisoners with disabilities were noted, and there was little in the way of in-cell facilities or specialist equipment. The ability of prisons to support prisoners with severe illness or requiring end-of-life care was limited. Within the prisons the quality of information exchange mechanisms was found to be problematic. Online connections with NHS databases were limited at best. Many older prisoners were reluctant to draw attention to themselves.

Though new initiatives such as day care and older men's clinics and gymnasia were noted, awareness of the needs of older prisoners and adequate preparation for release generally were limited.

Older prisoners require more support if the Prison Service is to fulfill its duty to house prisoners humanely and to support their rehabilitation.

S24.4

Mental illness in acute hospital settings

Depression, dementia, and delirium account for nearly 80% of mental disorder comorbidity in acute hospital settings.

Amongst these, delirium is a commonly occurring neuropsychiatric syndrome primarily characterized by impairment in cognition. There are well recognized, wide varieties of underlying etiologies for delirium, identification of which is part of clinical management. Delirium can occur at any age, and most studies focus on the elderly. On an average, approximately 20% of general hospital patients have delirium sometime during hospitalization. Delirium is associated with high rates of morbidity and mortality.

There are numerous assessment (screening and diagnostic) methods for delirium. Additionally, various etiologies have been linked with development and perpetuation of delirium. Research has found better outcomes, including reduced mortality, where active identification and treatment of delirium occurs. Delirium is an example par excellence of a syndrome requiring a multi-faceted biopsychosocial approach to assessment and treatment. Rapid treatment is important. Treatments include medication, environmental manipulation, and patient and family psychosocial support with use of medications, most commonly antipsychotics. Management can be preventative, of the actual episode, and post-episode. It can be non-pharmacological, pharmacological, or combined.

The focus for the presentation would be on delirium, along with its overlap with depression and dementia (especially in older people in an acute hospital set-up). It shall also attempt to provide an overview of the assessment and management strategies and recent updates in different areas so highlighted. An attempt shall also be made to critically evaluate the available research evidence.

S25.1

Efficacy and tolerability of treatment in STOP-PD: An age comparison

Alastair Flint

University of Toronto, Toronto, ON, Canada

259 patients with psychotic depression (n = 117 aged 18–59 years and n = 142 aged 60 years or older) were randomized to 12 weeks of treatment with either the combination of olanzapine and sertraline or the combination of olanzapine and placebo. Remission data, comparing treatment

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

groups and age groups, will be presented, based on intent-to-treat and completer analyses. Age groups will be compared on the frequency and causes of attrition and the frequency of adverse effects. The relation between participants' age and treatment-related metabolic effects will also be discussed.

S25.2

Age, cognition, and treatment outcome in psychotic depression

Ellen Whyte

University of Pittsburgh School of Medicine, Pittsburgh, PA, United States

Some studies suggest that, among younger patients, cognitive deficits in psychotic depression parallel those seen in schizophrenia. However, there has been little attention paid to cognitive function in older patients with psychotic depression or its association with treatment outcomes.

The aims of this session are to describe the cognitive profile of older subjects with psychotic depression and compare it with the cognitive profile of younger subjects, to describe the change in cognitive function in response to treatment, and to examine whether baseline cognitive profile is associated with ultimate treatment outcome.

S25.3

Relationships between mood congruence of psychotic depression and age, clinical characteristics and treatment response

Barnett Meyers

Weill Medical College of Cornell University, New York, NY, United States

The 259 STOP-PD subjects were classified for mood congruence of delusions based on whether any mood-incongruent delusions (that is, not associated with a depressive theme) were present. Overall, 56% of subjects were classified as entirely mood-congruent. Mood-congruent delusions were significantly more common in older participants. Congruent subjects had lower Brief Psychiatric Rating Scale positive symptom scores. However, mood-congruent and incongruent subjects were comparable for severity of depression, presence and severity of melancholic symptoms, and the bizarreness of the most prominent delusion. Consistent with previous literature, Schneiderian symptoms were present in a subgroup of psychotic depression subjects, but were more common in those classified as being mood-incongruent. Congruence of delusions did not predict treatment response.

S25.4

Discussion of symposium

Robert Baldwin

Manchester Royal Infirmary, Manchester, United Kingdom

Professor Baldwin, an expert in late-life depression and psychotic depression, will serve as a discussant for this symposium

S26.1

Overview of ECT in the geriatric population

Charles Kellner

UMDNJ-New Jersey Medical School, New York, NY, United States

This presentation will provide an overview of the use of ECT in the geriatric population. Topics covered will include patient selection for ECT, pre-ECT evaluation and laboratory assessment, the ECT consultation, and assessment of efficacy and side effects. Co-morbid medical illnesses, so common in the geriatric population, will be discussed in terms of their potential impact on ECT. Consent issues relevant to the geriatric population will be covered.

S26.2

ECT optimization in the geriatric population

Georgios Petrides

The Zucker Hillside North Shore Long Island Jewish Health System, Glen Oaks, NY, United States

This presentation will review recent advances in ECT technique that allow the treatment to be maximally effective with fewer side effects. Electrode placement, stimulus dosing and other clinical decision-making during a course of ECT will be covered. The concurrent use of ECT and psychotropic and systemic medications will be covered.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

S26.3

Continuation/maintenance treatment strategies after acute ECT in geriatric patients

William McDonald

Emory University School of Medicine, Atlanta, GA, United States

This presentation will review treatment strategies for prolonging remission after successful acute ECT in geriatric patients. The use of concomitant medications in the acute ECT phase, as well as pharmacotherapy strategies in the continuation/maintenance phase will be discussed. The use of continuation/maintenance ECT will be covered. Data from recently completed clinical trials (from the CORE and Columbia University groups) will be presented. Future directions for research in continuation therapies will be discussed.

S27.1

Preventing medication-related morbidity in long-term care

A Canadian Academy of Geriatric Psychiatry (CAGP) Symposium

Paula A. Rochon[1]; Jerry Gurwitz[2]; Geoff Anderson[3]; Nathan Herrmann[4]

[1]Canada; [2]Worcester, MA, United States; [3]Canada; [4]Canada

Long-term care homes are a setting of care for over 1.6 million people in the United States, and more than 70,000 individuals in the province of Ontario alone. Residents in these settings, are often prescribed multiple drug therapies and these often include psychoactive medications. Residents take on average seven to eight different medications each month. The challenges of appropriately prescribing medications in this group are great because residents of long-term care homes are a vulnerable population and are at risk for drug-related adverse events. Residents are on average more than 80 years old, 70% are women, most have multiple chronic medical conditions. The majority of residents have dementia. We will explore three general strategies to guide appropriate prescribing of medications focusing on psychoactive medications in the long-term care setting.

First, we will explore the role of evidence-based reviews, expert consensus conferences and clinical practice guidelines to improve prescribing practices. A first step towards improving prescribing in LTC is to understand the evidence for use of psychoactive medications with an appreciation of the specific vulnerabilities of the target population. Evidence-based reviews, expert consensus conferences, and clinical practice guidelines have attempted to do this. We will discuss such efforts aimed at psychoactive prescribing in LTC, and attempt to determine if there is any evidence that these approaches are successful.

Second, we will explore the role that computer based clinical decision support has played in guiding prescribing. Prescribing behaviour can be guided using clinical decision support. Medication errors resulting in preventable adverse drug events occur most often at the ordering and monitoring stages of pharmaceutical care, indicating that these stages are particularly important targets for strategies designed to improve medication safety in long-term care. We describe how a computer-based clinical decision support system can improve the quality of medication ordering and monitoring for residents in the long-term care setting.

Finally, we will explore the role that warnings can play to guide appropriate prescribing. Antipsychotic therapies are an example of a drug therapy where warnings related to their use have been issued. While these medications may have a role to play for the management of psychoses or severe behavioural problems, there is considerable variability in how these therapies are used between facilities. Warnings have been issued by Health Canada the Food and Drug Administration linking these therapies to serious adverse events. Despite the seriousness of these events, and the national warnings, the use of these therapies has not decreased. We discuss the role that warnings and other system level interventions can play in guiding prescribing behaviour.

S28.1

Post-mortem studies of morphometric abnormalities in frontal-subcortical circuits

Alan Thomas

Wolfson Research Centre, Institute for Ageing and Health, United Kingdom

Studies to date suggest cellular abnormalities are present in major depression but may be different in different age groups. In the prefrontal cortex a reduction in the density of glial cells in major depression has been reported in most studies in mid-life and mixed age groups with little evidence of neuronal abnormalities. However, in late-life depression no changes in glial density appear to occur but changes in pyramidal neurones have been

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

reported in both the dorsolateral and orbitofronal cortices, especially in cortical layers 3 and 5. Similar abnormalities have been identified in the caudate nucleus.

S28.2

Genetic and environmental predictors of MRI-based neuroimaging changes in late-life depression

Ian Hickie

Brain & Mind Research Institute, University of Sydney, Australia

Older persons with more severe forms of depression have increased rates of a range of deep white matter, subcortical nuclei and hippocampal abnormalities on MRI imaging. These changes are correlated with disability, cognitive dysfunction and impaired response to treatment. Predictors of these changes appear to include later age of onset of depression, as well as genetic and environmental risk factors to vascular disease and genetic risk factors to depressive disorders. Further elucidation of these risk factors may lead to more targeted prevention and early intervention programs for late-life depression. In Australia, we have begun to use these factors as the basis for specific depression prevention trials in community-based subjects with elevated depression symptom scores.

S28.3

Functional connectivity in late-life depression

John O'Brien

Wolfson Research Institute, Institute for Ageing and Health, United Kingdom

Late life depression is thought to be associated with frontostriatal dysfunction. Using resting state blood oxygen level dependent (BOLD) MR imaging, spontaneous low frequency signal fluctuations act as a measure of functional connectivity between brain regions. We studied 17 older people with recovered depression and 17 controls. In controls, significant functional connectivity was seen between caudate and frontal lobes. However, in depressed subjects functional connectivity was increased and present over a much wider brain area (including parietal, frontal, subcortical and limbic regions). These new data support the view that connectivity in mood regulating circuits is disrupted in late life depression and demonstrate the utility of resting BOLD as a non invasive probe of neural function.

S28.4

Blood pressure changes and late-life depression

Akshya Vasudev

Wolfson Research Institute, Institute for Ageing and Health, United Kingdom

White matter hyperintensities and vascular brain changes are present in late-life depression, though clinical studies usually do not report an excess of clinically determined vascular risk factors in this patient group. These studies have not assessed orthostatic hypotension, a recently recognised risk factor for white matter hyperintensities. We have investigated whether blood pressure changes and orthostatic hypotension occur in late-life depression and present novel data indicating there may be a relationship between depression and orthostatic blood pressure abnormalities.

S29.1

How to promote screening for cognitive impairment in primary care

Henry Brodaty[1]; Katrin Seeher[2]; Dimity Pond[3]; Brian Draper[4]

[1]University of New South Wales, Coogee, NSW, Australia; [2]University of New South Wales, Coogee, NSW, Australia; [3]University of Newcastle, Callaghan, NSW, Australia; [4]Euroa Centre, Prince of Wales Hospital, Randwick, NSW, Australia

Screening for cognitive impairment by primary care physicians (PCPs, general practitioners, GPs), while controversial, has been recommended as routine for targeted populations such as patients aged 75 years or more as a way of redressing the low rate of dementia diagnoses by GPs. Yet adoption of cognitive screening by GPs is insignificant compared to routine testing for hypertension or cancer. Reasons given by GPs include therapeutic nihilism, uncertainty about management strategies, lack of familiarity with screening tools and lack of time. In response to the latter, many cognitive screening instruments, which are quick, efficient and have good psychometric properties, have been developed; three have been recommended: the Mini-cog, Memory Impairment Scale and GPCOG.

Tools alone do not build success. Accurate and timely diagnoses require that these techniques be translated into practice by changing attitudes of doctors (and patients and their families) and by making tools easily accessible and useable. Attitudes can be shaped by incentives, such as

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

reimbursement for cognitive screening, scientific evidence of benefit, easy to implement steps for (rewarding) management of Alzheimer's disease and other dementias, availability of curative treatments and structural reform such as mandating annual comprehensive assessments for 75+ year olds. Accessibility can be promoted by having freely available instruments that require minimal training and equipment and by web-based testing that can be accessed in a single click, saved and downloaded.

We conclude that screening for cognitive impairment in people at risk of dementia can improve diagnostic accuracy, but that its introduction requires a comprehensive strategy supported by professional organisations, consumer groups and government combined and deliverable via flexible formats including internet technology.

S29.2

The Mini-Cog and cognitive screening in general practice

Soo Borson

University of Washington, Seattle, WA, United States

The Mini-Cog is a brief screen for cognitive impairment developed for applications in primary care and field studies of older adults where cognitive impairment is easily overlooked in earlier stages. Consisting of 3-word recall and an executive clock drawing task, the Mini-Cog is intended to identify individuals with cognitive impairment, rather than to screen for specific dementing diseases. It has been validated in both highly diverse community samples and population-based studies, identifies cognitive impairment more effectively than primary care doctors, and is less influenced by educational and ethnolinguistic variations than are long-established screens such as the Mini-Mental State Examination. It performs at least as well as the MMSE in head-to-head comparisons, but takes much less time and training for reliable use. Mini-Cog scores predict health literacy and potential risk for medication mismanagement in persons without a prior diagnosis of cognitive impairment or dementia. We successfully implemented the Mini-Cog for routine cognitive screening of older adults in two practices, using a randomized-by-clinic design in a primary care network. While treatment rates did not change as a result of the intervention, dementia diagnoses and specialty referral rates increased. New follow-up data from this study will compare persons initially failing the screen with an age-matched group of persons who passed, across 5-year cumulative rates of dementia diagnosis and evidence of potentially preventable acute care episodes.

S29.3

Cognitive screening with clock-drawing and executive measures: An update

Donald Royall

The University of Texas Health Science Center and the Audie L. Murphy Memorial Veterans Hospital Geriatric Research Education and Clinical Center (GRECC), San Antonio, TX, United States

Cognitive screening for dementia is controversial. The goals of screening should be to sensitively detect cases who may benefit from more detailed assessment. Current screening efforts are hampered by a lack of clinically meaningful symptomatic therapy and by a lack of disease specific preventive therapy.

This situation may be compounded by an Alzheimer's disease (AD) specific selection bias that permeates dementia case-finding. A more efficient approach may be to shift dementia screening efforts toward the cognitive correlates of functional outcomes. Chief among these are executive control functions (ECF). Screening with ECF measures identifies a much larger affected population, but sensitively detects non-AD cases with reversible and preventable cognitive impairments. This may shift the balance in favor of cognitive screening.

Unfortunately, only a few ECF measures are psychometrically practical for routine cognitive screening at the bedside. This presentation will focus on three of these, CLOX: An executive clock-drawing task, the Executive Interview (EXIT25) and the Telephone Executive Assessment Scale (TEXAS), derived from EXIT25 items

S29.4

Cognitive assessment in primary care: Reflections on a national survey of Canadian family physicians

Ross Upshur

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Global demographic transitions in the developed world portend a dramatic increase in the incidence and prevalence of cognitive impairment. As there is a limited availability of specialists such as

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

neurologists, psychogeriatricians, or geriatricians, much of the assessment and management of cognitive impairment will fall to primary care practitioners. Studies suggest that primary care providers are unprepared to face this challenge with cognitive impairments being unrecognized and undocumented. Available data indicate high rates of non-recognition and numerous obstacles to the identification of cognitive impairment such as lack of time, limited resources, lack of training, stigma, and unfamiliarity with symptoms. In many cases, recognition is delayed until a behavioural crisis occurs. Some studies indicate skepticism on the part of primary care physicians as to the benefits of early detection.

These findings highlight the need for further research of primary care physician attitudes towards cognitive screening. There are at present a wide variety of cognitive screening tools available, but the vast majority of specialists only use a small number of them. There is limited data on primary care physicians' attitudes towards cognitive screening. In addition, little is known regarding the screening tool preferences of primary care providers, and information is needed as to what characteristics primary care providers deem to be important in the ideal screening tool. In this workshop I will report the findings of a national survey examining the attitudes of practicing Canadian family physicians towards cognitive screening; identifying the tools being used for cognitive screening in the primary care setting; examining the perceived effectiveness of these screening tools in primary care and describing the top attributes of an ideal screening tool in primary care.

S30.1

Long-chain omega 3 poly-unsaturated fatty acids and neuropsychiatric symptoms in older persons: Data from the three-city study

Pascale Barberger-Gateau

INSERM U897, Bordeaux, France

Several epidemiological studies have shown a higher risk of dementia or cognitive decline in older persons having a low intake of fish, the major dietary source of long-chain omega 3 poly-unsaturated fatty acids (n-3 PUFA). Depression is also a risk factor for dementia, suggesting common underlying patho-physiological mechanisms. We examined the link between dietary intake or blood concentrations of long-chain n-3 PUFA and the co-existence or occurrence of depressive symptoms, poor self-rated health and cognitive decline in a sample of French older persons participating in the Three-City (3C) study.

The data come from the Bordeaux sample of the 3C study where 2104 community dwellers aged 65 and above were included in 1999–2000 and followed-up for 7 years. Dietary data were recorded at baseline and 2-year follow-up by food frequency questionnaires and 24-h recall. In Bordeaux, plasma fatty acids concentrations were measured in 1390 individuals. Depressive symptoms were assessed on the Center for Epidemiologic Studies-Depression (CES-D) scale. Lifetime major depressive episodes (MDE) were recorded on the Mini-International Neuropsychiatric Interview. Self-rated health was recorded on a five-level scale. Thorough neuropsychological testing was performed at baseline and at each follow-up, including Mini-Mental Status Examination (MMSE). All participants had neurological examination at baseline. Suspected cases of dementia at baseline and follow-up were confirmed by an independent committee of neurologists.

In cross-sectional analyses, regular fish consumers had better neuropsychological performances, better self-rated health, less cognitive complaints and lower depressive symptoms on the CES-D. Higher plasma eicosapentaenoic acid (EPA) concentration was associated with a lower severity of depressive symptoms, especially in those taking anti-depressive treatment. In longitudinal analyses, regular fish consumption and higher plasma EPA concentration were associated with a lower incidence of dementia, independently of depressive status. The inverse association between plasma docosahexaenoic acid (DHA) and incident dementia did not remain significant in multivariate models. However, higher ratios of arachidonic acid (AA) to DHA and of total n-6 to n-3 fatty acids were related to an increased risk of dementia, particularly in depressive subjects. Finally, higher EPA plasma concentration was associated with slower cognitive decline on Benton's Visual Retention Test only in depressed subjects or ApoE4 carriers. In subjects with past MDE and adjusting for current MDE, higher plasma DHA proportion was significantly related to slower cognitive decline on the MMSE In conclusion, a high proportion of long-chain n-3 PUFA, in particular EPA, in the diet or in plasma may decrease the risk of depressive symptoms, cognitive decline and occurrence of dementia. The interaction between EPA and depression on cognitive decline warrants further research. Intervention studies are necessary to rule out residual confounding and to ascertain the role of EPA for the prevention of depression and dementia in older persons.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

S30.2

Inflammation and neuropsychiatric symptoms in the elderly: Modulation by long-chain omega-3 fatty acids

Lucile Capuron

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Depression, cognitive dysfunction and impaired quality of life are frequent in the elderly. Recent theories have proposed that immune factors play a role in these alterations. These theories are supported by a rich database that substantiates the capacity of proinflammatory cytokines released during oxidative stress, tissue damage and destruction (and the resulting inflammation) to impact on neurotransmitter and neuroendocrine functions and induce behavioural symptoms. Aging is associated with chronic low-grade activation of the innate immune system, probably due to alterations in immune-regulatory pathways or/and insufficient antioxidant defenses. Given the notorious effects of inflammatory cytokines on behaviour, it is highly possible that inflammation participates in the pathophysiology of behavioural alterations in the elderly. Nutritional factors can have protective effects on neuropsychiatric symptoms. Micronutrients, including long-chain omega-3 fatty acids, are highly incorporated in the brain. In addition, these factors exert potent anti-inflammatory actions; a mechanism that could explain their effects on brain functions and behaviour. In this study, we assessed the possibility that long-chain omega-3 fatty acids can modulate neuroimmune interactions that ultimately influence mood and cognition. A sample of 300 elderly subjects were recruited from the Three-City (3C) study, an epidemiological cohort study which includes 9294 participants aged 65 and over, living in Bordeaux, Dijon and Montpellier, and recruited since 1999. Participants were drawn from the Bordeaux site and selected on the basis of their nutritional habits: poor versus regular consumption of long-chain omega-3 fatty acids. Subjects were submitted to a neuropsychiatric evaluation which included the assessment of mood, cognitive and neurovegetative symptoms. Blood draws were performed for the measurement of plasma inflammatory markers, including interleukin (IL)-6 and C reactive protein (CRP). Results indicated that nutritional habits significantly interact with inflammation to modulate behaviour. Participants with inflammation (defined as above median plasma level of interleukin 6 and C-reactive protein) and a regular consumption of long-chain omega-3 fatty acids reported less behavioural symptoms than participants with inflammation and poor long-chain omega-3 fatty acids intake. These results suggest that nutritional habits, notably as they relate to long chain omega-3 fatty acids consumption, can modulate the effects of inflammation on mood, cognitive and neurovegetative functions. A regular intake of the nutriments could reduce or prevent the detrimental effects of inflammation on behaviour.

S30.3

Eicosapentaenoic acid (EPA) omega-3 monotherapy of psychological distress and depressive symptoms among middle-aged women: A double-blind, placebo-controlled, randomized clinical trial

Michel Lucas

Centre Hospitalier de l'Université Laval (CHUL-CHUQ), Quebec, QC, Canada

Background: Menopausal transition is known to be associated with increasing vulnerability to psychological distress (PD) and depressive symptoms. Studies suggest that omega-3 supplements could be of benefit in depressive symptoms.
Objective: To compare EPA omega-3 monotherapy to placebo for the treatment of PD and depressive symptoms among middle-aged women.
Methods: 120 women aged between 40 and 55 years with moderate to severe PD were randomly assigned to 1.05 g/day of EPA plus 0.15 g/day of docosahexaenoic acid (n = 59) or placebo (n = 61) for 8 weeks. Main outcomes were 8-week changes in PD scores (Psychological General Well-Being (PGWB) Schedule) and depressive scales (20-item Hopkins Symptom Checklist Depression Scale (HSCL-D-20) and 21-item Hamilton Depression Rating Scale (HAM-D-21)).
Results: At baseline, PD women were mildly to moderately depressed, and 24% met DSM-IV major depressive episode (MDE) criteria. After 8 weeks of intervention, PD and depressive symptoms improved in both groups, but no significant differences were noted between them. Stratification analyses for MDE diagnosis at baseline indicated that in PD women without MDE (EPA n = 46, Placebo n = 45), EPA group differences from placebo in adjusted 8-week changes were 8.0 (95%CI: 0.6, 15.3; P = 0.034) for PGWB, –0.2 (95%CI: –0.01, –0.4; P = 0.040) for HSCL-D-20, and –2.7 (95%CI: –0.3, –5.1; P = 0.030) for HAM-D-21. Among PD women with MDE (EPA n = 13, Placebo n = 16), EPA group changes were not significant in comparison to the placebo group.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

Conclusions: To our knowledge, this is the first trial of omega-3 supplementation in the treatment of PD and depressive symptoms among middle-aged PD women. In all PD women, 8-week EPA omega-3 monotherapy failed to show benefits over placebo. However, stratification analyses for MDE diagnosis revealed that 8-week change on PD and depressive scales improved significantly in EPA group compared to placebo among PD women without MDE.

S31.1

Ethical principles in older people

A World Psychiatric Association (WPA) Symposium

Ilkin Icelli

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Since the early sixties, the medical profession has moved from physician oriented stance toward a physician-patient collaboration. Thus ethical issues arise every day for the psychiatrists who are involved in geriatric mental illness. That is why the geriatric psychiatrists face ethical and legal issues. While treating a mentally ill elderly, the treatment team has to utilize and respect many of the ethical principles that are common in the care of geriatric patients. If a medical difficulty with the ethical issues occurs, a consultation with other physicians and, if available, consultation of the ethic council of the hospital is recommended. On the other hand, the physician in the treatment process of the elderly patient with mental illness should act to respect the dignity and the personhood of him. For this issue there are regulations, statements, etc. In a recent conference on "Ethics and Capacity in older people with mental illness" held in September 2008, a consensus is prepared. One of the titles of this consensus was the ethical principles in older people. These principles include the respect for autonomy, beneficence/non maleficence, justice and veracity. Our aim is to give more information, to get the feedback of the participants and to provide a practical tool to all who are involved in ethical issues.

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S31.2

Rights to treatment, research and access to care

A World Psychiatric Association (WPA) Symposium

Edmond Chiu

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The ethical principle of distributive justice underpins the rights of the older person to all available forms of treatment for their medical conditions. However, the existence of ageism compounded by a strict, fundamental adherence to a person's utility to society, frequently negates this right. In the area of access to care and social services, the upholding of this principle must be strongly protected.

Their voluntary and informed contribution to research, thus adding to very needed sum of knowledge in the mental disorders of older persons, must be recognised, encouraged and applauded; while at the same time protecting them against harm and exploitation.

The interaction of ethical principles with their practical application in this area will be discussed.

S31.3

The reduction of stigma and discrimination: The situation in developing countries

A World Psychiatric Association (WPA) Symposium

Carlos Augusto de Mendonça Lima

Centro Hospitalar, Portugal

A prevailing double stigma attached to mental disorders in general and to the end of life in particular does not help old people to access necessary care. Older women may face further stigmatization, and poverty may lead to even further discrimination.

Old people living in developing countries are particularly exposed to the influence of poverty. Besides they are survivors in a context of several basic needs difficulties, the risk of health and mental health related to the old age make them particularly vulnerable to more exclusion.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

In the majority of these countries where the demographic inversion is just beginning, societies have to define priorities and the majority is in favor to support the reduction of childhood mortality and to create better conditions for the new generations.

Depending how this process is conducted, it can promote conflict among generations and exclude old people of society. The need to reduce stigma and discrimination is ethically mandated by their harmful consequences including perpetuation and worsening of mental illness. Neither chronological age nor dementia (or mental incapacity) should in itself be a reason to withhold beneficial treatment of psychiatric or physical conditions. Overall resource shortage does not justify discrimination against older people with mental illness.

Actions against stigma and discrimination of older persons with mental disorders leaving in such countries should start by an understanding of the value of old people for these societies and by the creation of opportunities where they can continue to contribute to the country development. Specific actions may reduce their charge for societies: one of them is to reduce the impact of health and mental disorders, offering treatments and care adapted to the context.

Strategies to reduce the stigma and discrimination in developing countries will be presented based on the WHO-WPA consensus statement on this matter (1).

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S31.4

Decision-making and relationships

A World Psychiatric Association (WPA) Symposium

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The decisions of older people with mental illness do not occur in a social vacuum. Decision-making is often influenced by relationships and conversely, mental disorders may affect decision making in regards to forming or severing relationships. Issues of undue influence sometimes arise when older people with mental disorders make decisions, as do questions regarding abuse and ability to consent when they enter into relationships. Health care practitioners are sometimes asked to assess or intervene in such situations. At the same time, the role of social support in the lives of older people and the need to support carers must be balanced with these concerns. This presentation will discuss: (i) the competing ethical principles of promoting autonomy and safety within relationships while preserving the role of carers; (ii) the role of carers in decision-making; (iii) the risk factors for undue influence in decision making; and (iv) assessment of risk and capacity in sexual relationships involving older people with mental disorders.

S33

Depression in Alzheimer's disease Study-2: Methods and initial presentation of results

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Non-cognitive, neuropsychiatric symptoms are common features of Alzheimer's disease (AD), producing significant disability for patients and significant burden for caregivers. Consequently the symptoms are frequently a treatment target. No therapies have been well established as effective, and concerns have arisen regarding the safety of antipsychotic therapies which have been widely used. Depressive symptoms have often been a target of pharmacologic therapy. Research on the efficacy of antidepressants for depressive symptoms in AD has been hampered by lack of systematic diagnosis, small sample sizes, and short-term follow up. To address these issues, the Depression in Alzheimer's disease Study-2 (DIADS-2) was conducted, with funding from the National Institute for Mental Health (NIMH). DIADS-2 was a randomized, placebo-controlled, multicenter trial to evaluate the efficacy and safety of the selective serotonin reuptake inhibitor sertraline for the treatment of depression in patients with AD. This multicenter study was conducted at Johns Hopkins University, the University of Southern California, University of Pennsylvania, University of Rochester, and Medical University of South Carolina. Between May 2004 and December 2007, 131 patients with a DSM-IV diagnosis of "dementia due to AD," who also met criteria for "Depression of Alzheimer's disease" (dAD) which used criteria developed by a working group convened by NIMH, were randomized to placebo or sertraline (target dose 100 mg per day). Participants were treated for 12 weeks under typical double-blind conditions. Participants and caregivers were also provided with a structured psychosocial intervention, targeting dementia. At

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

12 weeks after randomization, for ethical reasons, a priori rules allowed a subgroup of patients to proceed to open-label, doctors-choice therapy for an additional 12 weeks, extending close follow-up to 24 weeks. Patients and caregivers were assessed in person every 4 weeks.

The study's primary outcome measures were: ADCS-Clinical Global Impression of Change modified to focus on mood symptoms, remission of the depressive syndrome, and change over time in the mean score of Cornell Scale for Depression in Dementia. Other patient outcomes were assessed on standardized behavioral, cognitive, functional, and quality-of-life measures. Caregiver outcomes were also assessed. Safety outcomes were closely monitored as well. This symposium will present an overview of study methodology as well as safety and efficacy results from the 12-and 24-week study periods.

S33.1

Review the methodology efficacy and safety results, focused on primary analyses for the 12 weeks of the DIADS-2 study

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S33.2

Review of efficacy and safety results, focused on 24 week follow-up period

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S34.1

Strategies for treating cognitive disorders in China

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China is an aging nation, hosting an increasing number of patients with age-related disorders, e.g. dementias. Since the 1980s, dementia has drawn more and more attention in China, from basic research and clinical research to clinical service. The quality of health care and social services for patients with dementia and their families is improving. Government funded programs and non-profit organizations have been established to provide education, care, and support with regard to dementia. The recent advances in dementia care and research, including neuropsychological and neuroimaging studies, will be reviewed. In addition, the service model for individuals with cognitive impairment will be introduced, including a community-based screening program for individuals with suspected cognitive impairment, optimal diagnostic procedures and intervention strategies, and the caregiver support group intervention as well. Moreover, the application of alternative treatment, e.g., herbal medicines or compounds, will be briefly introduced. With gradually established infrastructure, it has provided a mature environment for dementia care and research in China. This may facilitate international collaboration, particularly to facilitate cross-cultural, ethnic comparative studies.

S34.2

Changing psychogeriatric service in Japan: Eight year experience of long-term care insurance policy

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Japan's medical cost has been doubled in two decades, from 160 billion US$, 6% of GDP in 1985 to320 billion US$, 9% of GDP in 2005, which is mainly due to the increase in medical cost for the elderly. Japan is a super-aged society in which the elderly (65 years old and above) comprises 20%, and the elder-elderly (75 years old and above) 9% of the population in 2005, respectively. In 2005 death rate has surmounted birth rate and Japan is expected to lose 25% of her population by year 2050. The medical cost for the elderly has been increased from 25% (in 1985) to 36% (in 2005) of the total medical cost.

Japan has launched Long-term Care Insurance (LTCI) Policy in 2000 to cope with the increasing number of the elderly population. The LTCI has been well accepted and the elderly covered by LTCI increased from 2.47 million (2000) to 4.18 million (2005), which is 16.6% of the elderly population. The elderly are evaluated by necessity for care and classified into six levels and are qualified to be taken care by public insurance policy.

Benefits of LTCI are enjoyed by fragile elderly in need of care, which has resulted in more than

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

half of the elderly live independent from their children. More Japanese thinks healthier than the elderly in other countries, however, it is partly due to more frequent use of medical service and care service.

Japan is now aiming to change the society in which the elderly is not dependent to the society, but is serving the man power supporting the society.

S34.3

Dementia in Korea: Its epidemic and a "war" against dementia

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The older population aged over 65 grew to 5.01 million in 2008, accounting for 10 per cent of the total population. About 420,000 senior citizens suffered from dementia last year, accounting for 8.4 per cent of the older population, and the number will likely increase further in the coming years as Korean population is rapidly aging. It is projected the number of persons with dementia will likely exceed the 1 million by the end of 2027. According to 2007 annual report of Korea National Health Insurance Corporation, number of medically treated persons with dementia was about 100,000, accounting for 23.8 per cent of all persons with dementia. Number of treated persons with dementia has been steeply rising recently. Dominant method of health insurance reimbursement is fee-for-service. DRG system is under experimentation, which includes Alzheimer's disease and other dementias. Last September, South Korea's government launched a "war" against dementia by unveiling a financial support program to help elderly citizens receive early diagnosis and treatment of dementia. Under the program, senior citizens will receive a free Alzheimer's checkup every two years, while those from low-income families will receive free treatment. Last January, the long-term care financing and delivery system was launched in order to cope with rapid population aging and dementia epidemic. The insurance system was designed to provide with an appropriate service that persons with dementia urgently needed such as institutional care, respite care, day care, home-helper service, home-visiting nurse service, allowance in kind, and cash allowance. However, hospitalization for medical treatment is not reimbursed by the long-term care insurance. Implementation of long-term care insurance scheme is expected to greatly reduce care burden of families with persons with dementia and stroke, while younger generation should shoulder heavier burden to pay for additional revenue for long-term care insurance on top of revenue for national health insurance. Well-designed, precise researches to meet unmet need of persons with dementia and their caregivers will be urgently necessary.

S34.4

Management of dementia in a Chinese community – perspectives from Hong Kong SAR

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Advancing age is associated with higher prevalence of dementia. Hong Kong SAR ranks among the top in life expectancy globally. There is an increasing need for proper care of demented elders in the community. With rapid advances in the understanding on the disease mechanisms about dementia, it is pertinent to consider translation of research findings into clinical significant management strategies.

Management of dementia in HKSAR may broadly be considered from two main perspectives. The first relates to tertiary prevention. Persons with clinical dementia should be detected and treated early to attenuate cognitive and functional deterioration, as well as to minimize emergence of distressing neuropsychiatric symptoms. A stage related approach and implementation of multi-disciplinary model of services is emphasized in Hong Kong. Persons with mild dementia are encouraged to receive treatment early, and assist to maintain community living. Persons with moderate and severe dementia require more specialized medical and social care. A comprehensive range of psychogeriatric services and evidence based programs are developing to address the special needs of demented elders suffering from significant psychiatric morbidity. A community based model may help to enhance accessibility and availability of care.

The second perspective relates to primary or secondary prevention. As knowledge base in dementia increases, the significance of mid-life and late life vascular risks and lifestyles in modulating

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press

cognitive decline is appreciated. There has been an increasing concern to adopt larger scale health promotion strategies on early detection of mild cognitive impairment. Attention to cerebrovascular risk factors, promotion of culturally acceptable physical exercise and leisure activity intervention will be important to enhance cognitive reserve of our older community.

The strategies for dementia care are not without hurdles. The resources are competitive and limited. There is a still a long way before our community is acceptable to the notion that dementia requires early and holistic intervention. Health care professionals are faced with challenges to bring this forward for enhancing the care of the emerging population with dementia.

https://doi.org/10.1017/S1041610209009314 Published online by Cambridge University Press