



# IPA INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION

## European Regional Meeting

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#### ABSTRACTS – POSTER SESSION 1

##### PS01-01 OSTEOPOROSIS: ASSESSING THE RISK OF FRAGILITY FRACTURE IN MEN OVER THE AGE OF 75 AND WOMEN OVER THE AGE 65 USING NICE SHORT CLINICAL GUIDELINES

Tania Saour\*

**Objectives:** To determine if NICE guidelines were being followed on Meridian Ward, Hammersmith & Fulham Mental Health Unit for assessing the risk of osteoporosis in both men aged over 75 and women aged 65 and over.

Guidelines include checking Vitamin D levels, Bone profile and by carrying out a DEXA scan.

**Methods:** Males over the age of 75 and females over the age of 65 were selected to take part.

I used both RIO computer system and cross checked with the pathology laboratory to see whether the selected patients have had a vitamin D and bone profile check since their admission.

Using both RIO computer systems and speaking to the DEXA scanning department at St Marys I was able to identify whether these patients had a DEXA scan since the date of admission, and if not whether they have had a DEXA scan requested.

**Results:** In this audit 11 patients out of 16 reached the criteria to take part.

Included are 9 female patients 2 male patients

The results showed that targets were not being met in majority of cases.

Out of a total 9 female patients 3 had a DEXA and out of 2 male patients one had a DEXA scan.

Out of a total 9 female patients 4 had their Vitamin D checked and out of 2 male patients both had their vitamin D checked.

In those who had their bloods tested we found Vitamin D levels as low as 24.4. This patient went on to have a DEXA scan which confirmed osteoporosis of the hip and spine. He was successfully treated with Cholecalciferol 20,000Units.

**Conclusion:** Investigating and preventing osteoporosis is very important in reducing long term disability and maintaining mobility in the elderly.

Patients may be on a large number of psychiatric medications which could increase their risk of osteoporosis further. Studies have shown higher rates of annual bone loss among antidepressant users and about 4% to 5% lower bone mineral density. This increases the likely hood of fractures. There is a well-established link between the use of antipsychotics, falls and fractures due to increased prolactin levels.

I devised a poster which was then placed on the wards and in several of the doctors offices. This informed nurses and doctors that patients will require a vitamin D, and bone profile check, along with a DEXA scan.

**Image:**

New admission?

Men over 75?

Women over 65?

**Think osteoporosis!**

Plan

Check Vitamin D !

Check Bone profile !

Request a DEXA scan !

**References:** NICE Guidelines (2012)- *Osteoporosis: fragility fracture risk* *Osteoporosis: assessing the risk of fragility fracture*. Short Clinical Guideline- CG 146 Evidence and recommendations

Pearce SH, Cheetham TD (2010); Diagnosis and management of vitamin D deficiency. *British Medical Journal*. 11;340:b5664

Summary Meeting Report (2004) *WHO Scientific group on the assessment of osteoporosis at primary Health care level*. Brussels, Belgium,

**Keywords:** antidepressants, antipsychotics, bone profile, DEXA scan, falls, Fragility fracture, Osteoporosis, Physical health, Vitamin D

**PS01-02 FACTORS DETERMINING THE BALANCE BETWEEN THE WISH TO DIE AND THE WISH TO LIVE IN OLDER ADULTS. AN EXPLORATIVE STUDY.**

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**Objectives:** The "Internal Struggle Hypothesis" (Kovacs & Beck, 1977) suggests that suicidal persons have both a wish to die and a wish to live which can be considered as distinct subjective phenomena given that the majority of suicide attempters reported "an internal debate" over whether to die or to live. The presence of a struggle between life and death was also reported by older suicidal adults (Wu, Tsao, & Huang, 2012) but the context of the presence of a wish to die differs in comparison to adult persons. In some cases for example, thoughts of death might be part of normal aging, whereas in other cases it might indicate an underlying psychopathology (Szanto et al., 2013). The purpose of the current study therefore was twofold: First, we explored whether the proposed typology - "wish to live", "ambivalent" and "wish to die" - is applicable to older adults, with and without psychopathology, since a wish to die might exist without an underlying mental disorder. Second, we aimed to explore whether an ordinal nature of this typology is reflected in group differences of variables, presumed to be robust risk factors of suicidality in later life.

**Methods:** The sample comprised 113 older inpatients from a psychiatric and somatic ward with a mean age of 74 years. Psychiatric diagnoses were assessed by the SCID-II. A discriminant analysis was conducted, creating two functions of a combination of social, psychiatric, psychological and somatic variables to predict the assignment of older inpatients into the three distinct groups "wish to live", "ambivalent" and "wish to die".

**Results:** The model with two discriminant functions ("subjective well-being" and "social support") allowed us to assign patients into these three distinct groups with good accuracy (66.1%). Function 1 (subjective well-being) contrasted the groups "wish to die" with the group "wish to live" and Function 2 (social support) discriminated between the group "wish to die" and the ambivalent group.

**Conclusion:** Results of this study indicate that the simultaneous presence of a wish to live and a wish to die exists in older inpatients and that the balance between them is determined by subjective well-being and social support.

**References:** Kovacs, M. and Beck, A. T. (1977). The wish to die and the wish to live in attempted suicides. *Journal of Clinical Psychology*, 33 (2), 361-365.

Szanto, K., Lenze, E. J., Waern, M., Duberstein, P., Bruce, M. L., Epstein-Lubow, G. and Conwell, Y. (2013). Research to reduce the suicide rate among older adults: methodology roadblocks and promising paradigms. *Psychiatric Services*, 64(6), 586-589.

Wu, G. H., Tsao, L. I. and Huang, H. C. (2012). Struggle between survival and death: the life experience of Taiwanese older adults with suicidal ideation. *Journal of Gerontological Nursing*, 38(5), 37-44.

**Please enter here the author's name, the company, and the nature of the relationship:** The study was funded by an unrestricted educational grant by Eli Lilly Belgium. The funding source had no role in the study design, collection, analysis and interpretation of results, in the writing of the report, or in the submission of the abstract

**PS01-03 COMMUNITY RESPONSE ENHANCED ASSESSMENT, CRISIS AND TREATMENT (REACT) SERVICE – EVALUATION OF THE SERVICE FROM QUANTITATIVE AND QUALITATIVE FEEDBACK FROM PATIENTS AND CARERS**

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**Objectives:** The Community REACT Service commenced on the 27 February 2012 and currently operates 7 days a week: 8.30am-8pm Monday to Friday and 9 am-5 pm at weekends and bank holidays. This is primarily a crisis intervention and home treatment service for older adults with both functional illnesses and dementia.

The innovative service strongly believes in its service evaluation on an ongoing basis. Collecting feedback from both patients and their carers has been in place since the commencement of the service in February 2012. Feedback is obtained when a patient is discharged from the service.

**AIM**

To evaluate the service by obtaining feedback from patients and carers.

**Methods:** Feedback forms were obtained from patients and carers upon discharge from the service, and these were studied in detail.

**Results:** The service is well received by both patients and carers. The feedback has been positive overall, with excellent qualitative feedback and quantitative scores. This will be presented in detail in the poster.

Patients have found treatment in their own home environment the most useful factor in their recovery. Carers have found the idea of early discharge from hospital with continued and more frequent support in their own home most appealing.

**Conclusion:** Patients and carers have commented positively on the continuity of care from mental health nurses and immediate access to Consultant. It is noteworthy that the service evolved by introducing the new model of care (more continuity of care and rapid access to Consultant) after studying the feedback from patients and carers.

There are further plans to obtain feedback from the referrers to Community REACT service.

Reflective practice sessions for the team based on the feedback from patients and carers is planned once in 3 months.

A focus group for qualitative feedback from patients and carers with ethos to further improve the service is planned.

**Keywords:** caregiver feedback, patient feedback, REACT service, service evaluation

## PS01-04 WHAT IS SPECIAL ABOUT DEMENTIA SPECIAL CARE UNITS IN GERMAN NURSING HOMES?

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**Objectives:** Care units (CU) specialised for people with dementia (PwD) are an important feature of nursing homes. One third of German nursing homes provide any type of specialised CU (Schneekloth and Törne, 2009). A variety of these CUs developed worldwide, they differ in their living and care concept, size and funding (Ohta and Ohta, 1988). Less is known about their structural characteristics and an international definition is lacking. The structural diversity of CUs exacerbates the comparison of international study findings, so that a strong evidence on the question in which nursing home setting PwD are best served, is missing (Zimmerman et al., 2013).

This study explored characteristics of the environment and staff from different CU types to identify special features of them and provide a basis for future evaluation research.

**Methods:** Cross-sectional study comparing five different types of CUs, that were defined based on their living concept (segregated and integrated), size (small and large scale), and funding (extra funded and not extra funded). Investigated structural characteristics comprised organisation and staff. Differences were identified using descriptive statistics, Chi-Square resp. Kruskal-Wallis-Test and post-hoc analysis with Bonferroni corrections.

**Results:** In total, 103 CUs from 51 nursing homes participated: 63 integrated and 40 segregated CUs; 48 integrated and 31 segregated CUs were large. Sixteen large segregated CUs were extra funded. Small CUs provided exclusively single rooms, large segregated CUs made single rooms available for 50% of the residents. More than 80% of the segregated CUs were located in a building that was constructed especially for PwD, but less than 35% of the integrated CUs. Large integrated CUs cooked less often meals in the CU than others. Regarding the staff, small CUs provided more staff, but they were not exclusively assigned to the CUs. Large segregated CUs with extra funding provided more registered nurses and nurses with a special qualification per resident than the other large CUs.

**Conclusion:** Because single room availability, provision of meals, staff quantity, quality and continuity may influence residents' outcomes (Fleming and Purandare, 2010, Zimmerman et al., 2005, Abrahamson et al., 2013), it is necessary to investigate whether differences are apparent in future evaluation studies of specialised CUs for PwD.

**References:** ABRAHAMSON, K., LEWIS, T., PERKINS, A., CLARK, D., NAZIR, A. & ARLING, G. 2013. The Influence of Cognitive Impairment, Special Care Unit Placement, and Nursing Facility Characteristics on Resident Quality of Life. *J Aging Health*, 25, 574-88. FLEMING, R. & PURANDARE, N. 2010. Long-term care for people with dementia: environmental design guidelines. *Int Psychogeriatr*, 22, 1084-96.

OHTA, R. J. & OHTA, B. M. 1988. Special units for Alzheimer's disease patients: a critical look. *Gerontologist*, 28, 803-8.

SCHNEEKLOTH, U. & TÖRNE, I. 2009. Entwicklungstrends in der stationären Versorgung - Ergebnisse der Infratest-Repräsentativerhebung. In: SCHNEEKLOTH, U. & WAHL, H. W. (eds.) *Pflegebedarf und Versorgungssituation bei älteren Menschen in Heimen*. Stuttgart: Kohlhammer Verlag.

ZIMMERMAN, S., ANDERSON, W. L., BRODE, S., JONAS, D., LUX, L., BEEBER, A. S., WATSON, L. C., VISWANATHAN, M., LOHR, K. N. & SLOANE, P. D. 2013. Systematic review: Effective characteristics of nursing homes and other residential long-term care settings for people with dementia. *J Am Geriatr Soc*, 61, 1399-409.

ZIMMERMAN, S., SLOANE, P. D., WILLIAMS, C. S., REED, P. S., PREISSER, J. S., ECKERT, J. K., BOUSTANI, M. & DOBBS, D. 2005. Dementia care and quality of life in assisted living and nursing homes. *Gerontologist*, 45 Spec No 1, 133-46.

**Keywords:** dementia, nursing home, special care unit

## PS01-05 ACTIVE AGEING AND PARTICIPATION IN THE NURSING HOME: A MULTI METHOD PATHWAY LEADING TO THE DESIGN OF AN INTERVENTION

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**Objectives:** Active Ageing (AA) is an increasingly important concept in gerontology. AA aims to optimise opportunities in health, participation and security in order to enhance the quality of life (QoL) of older people (WHO, 2002). Since AA in nursing homes (NH) has not been developed yet, the aim is to examine how AA can be translated to and implemented in this setting. The various phases of this project, leading to the design of an intervention to attain AA in the NH are reported here.

**Methods:** First, a qualitative study on what AA could entail in the NH was conducted. A thematic analysis was performed on data from 4 semi-structured focus groups (residents; children of residents; community-dwelling older people; experts) (Van Malderen et al., 2013a). Secondly, a systematic review on interventions which intend to improve the QoL of residents was completed (Van Malderen et al., 2013b). Finally, a 61-item questionnaire to measure the realization of AA in NH was developed and administered to 263 residents in 44 NH in Flanders. Also the relation with QoL, as measured by Anamnestic Comparative Self Assessment (ACSA) (Bernheim, 1999), was explored.

**Results:** The qualitative study revealed 9 AA-determinants relevant for the NH: Culture, Behaviour, Psychological Factors, Physical Environment, Social Environment, Economical Factors, Care, Meaningful Leisure and Participation. Participation was seen as pivotal to AA. The systematic review identified 35 interventions, which could all be assigned to one or more of these AA-determinants, mainly to Physical Environment and Psychological Factors. Effects on QoL were not systematically present. In our survey study, residents estimated that 71% of the AA aspects in their NH had been realised, ranging from 64% (social environment) to 78% (behaviour determinant). Participation scored 69%. There was a significant positive relationship between QoL and the experienced AA ( $r = .39$ ;  $p < .05$ ).

**Conclusion:** AA is important, even in the NH. As showed by our studies, however, adequate AA-interventions are still needed to improve the QoL of residents. Since participation of the residents seemed to be a key factor of AA, Participatory Action Research (PAR) might be a method to empower residents and to increase their autonomy. In PAR, residents make recommendations for improvements, by systematically observing the NH-functioning, identifying problems and making suggestions for solutions. This intervention is currently under research by an RCT.

### References:

Bernheim, J L (1999). How to get serious answers to the serious question: "How have you been?": subjective quality of life (QOL) as an individual experiential emergent construct. *Bioethics*, 13 (3-4), 272-287

Van Malderen L, Mets T, De Vriendt P & Gorus E (2013a). The active ageing–concept translated to the residential long-term care. *Quality of Life Research*, 22 (5): 929-937.

Van Malderen L, Mets T & Gorus E (2013b). Interventions to enhance the quality of life of older people in residential long-term care: A systematic review. *Ageing Research Reviews*, 12 (1): 141-150.

World Health Organisation (2002). Active Ageing: a policy framework. Geneva: World Health Organisation.

**Keywords:** long term care, quality of life, residential facilities

## PS01-06 DELIRIUM AND NEGATIVE CLINICAL CONSEQUENCES

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**Objectives:** Delirium is a common and complex clinical neuropsychiatric syndrome, affecting as much as 50% of elderly people in hospital (Inouye *et al.*, 2014). It has been associated with numerous negative outcomes, such as increased length of hospital stay, risk of death, institutionalization and dementia (Witlox *et al.*, 2010; Leentjen *et al.*, 2012). The aim of this study is to analyze the contribution of delirium to adverse clinical consequences in elderly patients.

**Methods:** The sample included elderly patients ( $\geq 65$  years) admitted ( $\geq 48$ h) into two intermediate care units (IMCU) of Intensive Medicine and Surgical Services (CHSJ/Porto). Exclusion criteria were: a total score  $\leq 11$  on the Glasgow Coma Scale (Teasdale and Jennett, 1974), blindness/deafness, inability to communicate and to speak Portuguese. Delirium was operationally defined according to the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR) criteria (American Psychiatric Association, 2000).

**Results:** The final sample (N=208), with a mean age of 78.3 (sd=7.8), were majority female (53.8%), married (53.4%) and with low education level (92.4%). The most common reasons for admission were cardiorespiratory problems (44.3%) and the occurrence rate of delirium was 25%. Significant differences were noted for admission type ( $p=0.008$ ) and length of stay in the IMCU ( $p<0.001$ ), with the delirium group presenting the highest duration of hospitalization. There was also a difference for the total number of comorbidities, revealing a fairly higher value ( $p=0.049$ ) in the group without delirium. No significant differences for the admission diagnosis and daily medications were found.

**Conclusion:** These results suggest that delirium in elderly hospitalized patients is associated with negative clinical consequences. In this way, the implementation of interventions to prevent and improve management of this syndrome should be a priority.

**Acknowledgements:** This work was supported by the Foundation for Science and Technology (SFRH/BD/63154/2009).

**References:** American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV-TR, 4th ed., revised. Washington, DC: American Psychiatric Association.

Inouye, S. K., Westendorp, R. G., and Saczynski, J. S. (2014). Delirium in elderly people. *The Lancet*, 383(9920), 911-922. doi: 10.1016/S0140-6736(13)60688-1.

Leentjens, A. F. *et al.* (2012). Delirium: An evidence-based medicine (EBM) monograph for psychosomatic medicine practice, commissioned by the Academy of Psychosomatic Medicine (APM) and the European Association of Consultation Liaison Psychiatry and Psychosomatics (EACLPP). *The Journal of Psychosomatic Research*, 73(2), 149-152. doi: 10.1016/j.jpsychores.2012.05.009

Teasdale, G., and Jennett, B. (1974). Assessment of coma and impaired consciousness: a practical scale. *The Lancet*, 304(7872), 81-84.

Witlox, J., Eurelings, L.S., de Jonghe, J.F., Kalisvaart, K.J., Eikelenboom, P., and van Gool, W.A. (2010). Delirium in elderly patients and the risk of postdischarge mortality, institutionalization, and dementia: a meta-analysis. *JAMA*, 304(4):443-51. doi: 10.1001/jama.2010.1013.

**Keywords:** Delirium, Elderly

## PS01-07 DELIRIUM, DO YOU RECOVER?

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**Objectives:** Delirium is a common neuropsychiatric condition. The natural course is of an acute, fluctuating and often transient condition; however, accumulating evidence suggests delirium can be associated with incomplete recovery.

**Objective:** To clarify the definition of recovery of delirium used in the literature.

**Methods:** A Medline search was performed using relevant keywords. Studies were included if they were in English, provided any definition of recovery, and were longitudinal. Excluded articles were duplicated studies, case studies, review articles or articles related to alcohol, children, subsyndromal delirium only or core symptoms such as function

**Results:** Fifty-six studies met the inclusion criteria. Only 2 studies used clinical criteria alone for the diagnosis, most studies used at least one validated scale. 16 different terms were used to define the "recovery of delirium". The definitions also varied. Studies using severity scales used either cut-off points or percentage reduction between assessments while others using dichotomous scales (yes/no) defined as recovery one or more days of negative delirium as the end point.

**Conclusion:** An agreed terminology to define recovery in delirium is required. A distinction should also be made between symptomatic and overall recovery as well as between long and short term outcomes. It is proposed that cognition recovery may be used as outcome to identify recovery of delirium.

**Keywords:** Delirium, recovery

**PS01-08 DEVELOPMENT AND VALIDATION OF 'THE ADVANCED ACTIVITIES OF DAILY LIVING TOOL' ALLOWING THE EVALUATION OF SUBTLE FUNCTIONAL DECLINE IN MILD COGNITIVE IMPAIRMENT**

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**Objectives:** Mild Cognitive Impairment (MCI) is of foremost importance given its high conversion rate to dementia. Evaluation of advanced Activities of Daily Living (a-ADL), which are the most complex and cognitive demanding activities within the whole ADL spectrum might be a discriminativ to distinguish between MCI and dementia, but there is no consensus on its evaluation in MCI. Therefore a new, innovative tool was developed and validated .

**Methods:** First, in a qualitative design (n=38), content and face validity was tested. Secondly, in a quantitative study, feasibility, reliability (inter-rater, patient-proxy report), construct validity (correlations and expected differences between groups) and discriminating validity (ROC ) were tested.

Fifty-three MCI patients (diagnostic criteria of the Working Group on MCI, 2004), 52 patient with mild Alzheimer's Disease (AD) (DSM IV, ICD 10) and 50 Healthy controls (HC) were included. All were evaluated with a comprehensive set of standard cognitive, emotional and functional assessments and additionally with the a-ADL tool.

**Results:** The qualitative study resulted in the a-ADL tool, which comprises 49 activities organized in 15 clusters based on the International Classification of Functioning, Disability and Health (ICF, WHO, 2001) with an operationalization of the ICF scoring system from 0 to 4. The evaluation, taking each person as his own reference, is based on the total number of activities performed by the person and the severity of the problems occurring. It distinguish a Disability Index (a-ADL-DI) taking into account all activities and the severity of the impairment, a Cognitive Disability Index (a-ADL-CDI) and a Physical Disability Index (a-ADL-PDI) taking into account only those activities impaired due to or cognitive or physical problems. Inter-rater reliability was excellent (ICC ranging from .975 to .996, all  $p < .001$ ). Overall agreement between patient proxy was excellent (ICC .998,  $p < .001$ ). Correlations between a-ADL DI/CDI and cognitive measures (MMSE and CamCog) ranged from .688 to .714 ( $p < .001$ ). Significant differences between groups were as expected (HC > MCI > AD). The discriminative power of the a-ADL DI/CDI ranged from an AUC of .789 to .960.

**Conclusion:** The new a-ADL tool shows good to excellent psychometric properties and might offer a useful contribution to the diagnosis of patients with mild cognitive disorders in an older population. Ongoing studies are targeting the predictive and convergent validity.

**References:** De Vriendt P, Gorus E, Cornelis E, Velghe A, Petrovic M, Mets T. The process of decline in advanced activities of daily living: a qualitative explorative study in mild cognitive impairment. *Int Psychogeriatr.* 2012 , 24(6): 974-86.

De Vriendt P, Gorus E, Cornelis E, Velghe A, Petrovic M, Mets T. The Advanced Activities of Daily Living: a tool allowing the evaluation of subtle functional decline in Mild Cognitive Impairment. *JNHA* 2013, 17 (1): 64-71.

De Vriendt P, Mets T, Petrovic M, Gorus E. Discriminative power of the advanced Activities of Daily Living tool in the diagnosis of Mild Cognitive Impairment in an older population. Submitted for publication.

**Keywords:** ADL assessment, Dementia, functional decline, Mild cognitive impairment

**PS01-10 IMPROVING UNDERSTANDING AND RECRUITMENT INTO RESEARCH IN A SPECIALIST COGNITIVE IMPAIRMENT AND DEMENTIA SERVICE**

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**Objectives:** Following the NHS's program promoting early identification of people with dementia (Living well with dementia: a national dementia strategy 2009), there is an increase in individuals coming forward to be seen by clinicians with early signs of cognitive decline. However, with limited treatment options available for those receiving a diagnosis of dementia, the G8 dementia summit, (2013) set out ambitions to identify curative or disease modifying treatments by 2025 and increase participation in dementia research studies. At the frontline, we wanted to explore areas where clinicians felt least confident about recruitment into research. We aimed to identify areas which could improve the clinicians' knowledge base; the procedures involved and facilitate the recruitment of patients to a research register.

**Methods:** Using a training forum for all members of staff within a specialist CIDS as the platform, all members of staff were asked in the first session to fill in a survey. The results were fed back a month later at the next meeting and reflected upon. A number of action points were identified. An evaluation of the impact of interventions discussed is due to be carried out in November.

**Results:** The results showed that almost all clinicians were aware of the importance of research and the research register and appreciated the relevance to current practice. However, they highlighted the need for more support to recruit patients. There was a strong theme of clinicians not feeling confident of what they were recruiting patients into i.e. the potential trials, the processes involved and outcomes. There was a focus on improving information sharing between the research unit and dementia services, particularly with regards to on-going projects and the results of previous projects. The action was that monthly information emails would be circulated, giving updates on trials, rates of recruitment to the database and outcomes. Patient information sheets and consent forms were also felt to be too complex and these needed to be vastly simplified not only for ease of discussion but also for time constraints. Effort might be spent to develop study summary sheets to accompany the main patient information sheet for clinicians to be able to speak to their patients about research and the research register. The results in terms of recruitment rates will be further presented in the poster.

**Conclusion:** This will highlight how the results have led to a change in practice and improvement in recruitment of patients.

**References:** 1. Department of Health, 2009, Living well with dementia; A National Dementia Strategy, London, Department of Health  
2. Department of Health, 2013, Dementia Challenge, (online) Available at:<http://dementiachallenge.dh.gov.uk/2013/12/12/g8-dementia-summit-agreements/> (accessed 1st October 2014)

## PS01-11 IS THE GERIATRIC DEPRESSION SCALE A USEFUL SCREENING TOOL?

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**Objectives:** Depression increases the risk factor for suicide but also for a chronic course of physical disease. The Geriatric Depressions Scale (GDS-30, GDS-15) is depression screening instrument specifically developed for the elderly. The objective is to provide a systematic review of the screening accuracy of both GDS versions.

**Methods:** An electronic search was performed using Medline, Embase, Cinahl, Psyn dex and Cochrane library. The selection and examination of papers was done by two reviewers independently. Studies were excluded if the number of depression cases was less than 10, if no clear case criterion was used, or if merely phone versions were used or the sample included only psychiatric patients.

**Results:** Of 173 papers which were read and examined, only 42 papers were included. For both GDS versions similar mean validity indices were found (GDS-30: sensitivity 0.753, specificity 0.770; GDS-15: sensitivity 0.805, specificity 0.750). Using pooled samples we could not find significant differences between the two versions of the GDS. Using comparative studies based on identical samples, both GDS versions showed significantly better validity indices than the "Yale-1-question" screen, but did not differ from the CES-D. Frequently, essential information about research methods was not given. When methods were reported, the differing methods (e.g. concerning blinding, cut-off values, sampling procedures) limit the comparability of primary studies.

**Conclusion:** Overall, the GDS seems to be sufficient for screening of depression in everyday clinical work. Nevertheless, the GDS did not show advantages as compared to usual screening tools such as CES-D.

**Keywords:** depression, screening

**PS01-12 A NEWSPAPER SURVEY OF ELOPING INCIDENTS IN ELDERLY PATIENTS WITH DEMENTIA IN GALICIA (SPAIN)**

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**Objectives:** As dementia evolves patients are more likely to suffer a missing incident being unable to return home. International studies however are scarce and focused on the US, Hong Kong, Japan... As far as we know there is no European study on missing incidents in Patients with dementia (PWD).

**Methods:** In the Galician study a retrospective design was used to analyse newspaper reports of PwD missing in the community. Data from Galicia (2.765.940 inhabitants) was obtained from the local newspaper with highest share (circulation 580.000, 45.9% share), using the newspaper database (1995- 2012). Suicide cases and violent deaths were excluded. Sociodemographic data, variables related with the episode, and rescue strategies were recorded.

**Results:** This search rendered 240 news that made reference to 126 cases. Mean age was 79.3 years, without significant gender differences. 57.6% of cases were found by relatives and/or neighbours. Interestingly the missing person was found alive in 54.9%, in a radius <1000 meters from the place last seen in 73.1% of these cases. The missing person was found in the first 3 days of the event in 74.1% of cases.

**Conclusion:** Missing PwD in Galicia are usually found by relatives or neighbours in a reduced perimeter from home and frequently in the first 3 days of the disappearance. The first 24 hours are crucial for being rescued alive, and in a majority of cases the incident took place during a permitted walk.

Given the heterogeneity of European societies from the socio-demographic point of view, health and security systems and the increasing aging population, it would be interesting to compare the prevalence of missing incidents, their outcome and characteristics across a range of European countries as well as the searching strategies in use, in order to devise a European strategy for prevention and safe return.

**Keywords:** dementia, eloping, missing, wandering

## PS01-13 SCREENING FOR DEPRESSION IN PATIENTS WITH COGNITIVE IMPAIRMENT

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**Objectives:** Depression is highly prevalent in cognitive impairment. NICE (2010) Guidelines on Dementia advise “at the time of diagnosis, and regularly afterwards, assess medical and psychiatric co-morbidities, including depression and psychosis”. The purpose of this audit was to ascertain whether patients presenting with cognitive problems at Memory Services in a south London mental health trust are being screened for depression.

**Methods:** Patients referred to the memory services across the trust during the first 6 months of 2012 were selected. The cohort was chosen by stratifying the referrals during this period so that every fourth referral chronologically was selected. The first 3 meetings with each patient were reviewed on the electronic notes. It was noted whether mood was assessed and whether any standardised screening tool was used to assess mood. If a patient was on treatment for depression, then it was noted whether there was documentation of discussion about this with patient or carer.

**Results:** Across the trust, 229 patient notes were reviewed. Of these, 19 (8%) were not assessed due to the patient declining assessment, the patient moving area or the death of the patient. The patients predominately had an organic diagnosis with some diagnosed with an affective disorder. 179 (85%) did not have an existing diagnosis of depression. Of these, 149 (83%) had their mood assessed when they presented at services with 8 (4%) using a standardised screening tool. This was the Geriatric Depression scale (GDS) in all cases. 31 (15%) had an existing diagnosis of depression. Of these, 27 (87%) had documentation of their mood at assessment with 2 (6%) using the GDS or Cornell Scale. There were 34 patients on medication for depression. Of these, 16 (47%) had documentation in their notes of a discussion about treatment with patient or carer.

**Conclusion:** Generally an assessment of mood is considered at referral to memory services. However, a significant number (16%) did not have any reference to mood assessment in their notes. This is important due to the association between depression and cognitive impairment. Another finding from this audit is the need to improve on the documentation of discussions about treatment with the patients and their careers. Dissemination of these results within the directorate has been undertaken and training has been implemented across the multi-disciplinary team.

**References:** NICE (2010) Dementia Quality Standard [Online]. Available at <http://publications.nice.org.uk/dementia-quality-standard-qs1/introduction-and-overview>

**Keywords:** cognitive impairment, depression, memory service, screening

## PS01-15 PREDICTING THE RISK OF FUTURE DEMENTIA USING MILD COGNITIVE IMPAIRMENT DEFINITIONS

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**Objectives:** A key research focus in the field of dementia has been identifying those individuals at high risk of future disease in the hope that interventions can be implemented early enough to delay the onset of dementia. Mild cognitive impairment (MCI) is a term used to describe the transitional state between normal cognition and clinical dementia. Numerous different definitions exist to operationalise this state. A previous systematic review of the predictive accuracy of MCI for incident dementia identified seven publications but found that no criteria had sensitivity and specificity of over 80% nor did they display sufficient discrimination to be recommended for clinical usage (Stephan *et al.*, 2010). In this review we describe how dementia risk models using MCI definitions tested in population-based samples have evolved since the last review.

**Methods:** The search included all literature published between the 1 January 2009 to 17<sup>th</sup> March 2014. Only articles published in English were considered. MEDLINE, Embase, Scopus and ISI Web of Science were searched. Population-based studies examining risk of dementia in non-demented individuals with MCI, which included measurements of sensitivity, specificity or the AUC/c-statistic were included.

**Results:** 1,258 articles retrieved after duplicates were removed. Six publications met the inclusion criteria. The studies included varied in terms of sample size (range 362 – 3214), age at baseline (mean age range 60.0 – 79.7) follow-up time (1.4 to 8 years), and dementia diagnosis criteria. In general, Mayo-clinic defined MCI criteria generally exhibit low sensitivity and moderate to high specificity when used to identify those at risk of dementia. Three new issues have arisen compared to our earlier review. Firstly, the concept of risk stratification within MCI itself; secondly, the need to improve the definitions with the incorporation of other factors associated with cognitive impairment; thirdly, the use of MCI definitions to predict incident dementia in at-risk populations such as those who have had a stroke.

**Conclusion:** Current definitions of MCI remain restrictive; some more inclusive and broad definitions are required if we are to use MCI to identify those that will progress to dementia. Methods to risk stratify individuals based on MCI case definitions and/or the addition of other factors known to be associated with dementia has the potential to improve these definitions to assist in earlier detection of incident dementia.

**References:** Stephan, B.C.M., Kurth, T., Matthews, F.E., Brayne, C. and Dufouil, C. (2010) 'Dementia risk prediction in the population: are screening models accurate?', *Nat Rev Neurol*, 6(6), pp. 318 - 326.

**Keywords:** Mild cognitive impairment, modelling, prediction, risk

## PS01-16 INTEGRATED PSYCHOGERIATRIC CARE: THE USE OF TELE-HEALTH IN UNDERSERVED AREAS

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**Objectives:** In Greece, mental health care for elderly in rural areas is missing. Elderly are frequently afflicted by more than one pathological condition and are more vulnerable to dementia and depression, diseases that are of chronic nature and require repeated monitoring. Such patients face the greatest difficulties to gain access to mental health care services. In the context of a major tele-psychiatric project, the 1st Department of Psychiatry developed a tele-psychogeriatric service, consisting of a tele-psychogeriatric unit (T-psyGU) and a mobile tele-psychogeriatric unit (MT-psyGU) with the use of iPad. The aim of this program was the delivery of diagnostic, therapeutic and educational approaches to demented or depressed patients and their families, that live in remote and underserved areas, through the implementation of new technology in the geriatric mental health care delivery system.

**Methods:**

- Setting: rural and urban underserved areas (the Health Center of Andros Island and the Community of Keratea)
- Staffing: social workers and psychologists supervised by geriatric psychiatrists based at Eginition Hospital
- Intervention: standard protocols to screen, identify and treat depression, dementia and BPSD
- Technology: iPad and android technology able to transmit and receive patient''
- Funding: Stavros Niarhos Foundation (SNf)

**Results:** During 2013, 220 videoconference appointments took place both in the Health Center of Andros Island and Keratea region and 48 ones in patients' homes. Among them, a total of 62 new cases of depression and dementia were diagnosed, while 40 old cases were monitored. 7 patient admissions were arranged.

Compared to usual care the intervention resulted in better recognition of BPSD and less use of antipsychotics or sedative-hypnotics. Caregivers showed improvement in distress and they expressed their satisfaction about the new service. Fewer visits to tertiary care were recorded and the intervention resulted in faster resolution of suicidal ideation.

**Conclusion:** The successful application of this integrated collaborative service through communication technology in geriatric mental health care offers the opportunity to mental health specialists to reach elderly people in remote areas. It seems that, in the near future, telepsychogeriatrics is going to experience further evolution, since the needs of geriatric population increase constantly and both technology and mental health providers, more technologically literate, expand rapidly.

**Keywords:** telepsychogeriatrics, dementia care, old age depression

**PS01-17 ARE GENERAL PRACTITIONERS EQUIPPED TO HELP THEIR DEMENTIA PATIENTS ACCESS ASSISTIVE TECHNOLOGY?**

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**Objectives:** To explore General Practitioners' (GPs) levels of knowledge around the range of, and role of, assistive technology (AT) in dementia care

**Methods:** A mixed methods study was conducted. This involved two work streams (WS). WS1: a scoping questionnaire to GP trainees (GPT) during a national conference. Thirty people participated; 26 academic GPTs and 4 senior GP academics. WS2: semi-structured interviews with GPs working in the North East of England. Purposive sampling was used to select a range of GPs, GPT's and GPs with a commissioning role. 14 people participated including: 9 GPs (5 with a commissioning role) and 5 GPTs. Interviews took place between April 2014 and July 2014. The interview schedule was developed based on a literature review to identify key themes (Robinson et al, 2013; Newton and Robinson, 2013). A framework of AT products (Gibson et al, 2014) and pictures of devices were used to guide interviews. Data was analysed using the constant comparative method.

**Results:** WS1: This group did not feel confident enough to provide information about AT to patients or know how to make appropriate referrals to other AT services; these areas were explored in WS2. WS2: GPs had a general lack of awareness of AT. Two major categories emerged from the data: personal knowledge and awareness and system knowledge and awareness. Many had only heard of a few dementia specific devices; the majority had seen community alarm services in their clinical practice but had little familiarity with other AT products suitable for use in dementia care. GP's wider knowledge regarding AT provision was also limited with specific problems with GP's knowledge regarding where to get information, who to refer their patients to, or who should commission AT being highlighted.

**Conclusion:** There is a disappointing lack of GP awareness of the use of AT in dementia care. In order to integrate AT into routine dementia care, greater attention needs to be paid to the role GP's and GP based commissioning plays in the provision of AT services.

**References:** Gibson, G., Newton, L., Pritchard, G., Finch, T., Brittain, K, and Robinson, (2014) 'The provision of assistive technology products and services for people with dementia in the United Kingdom' *Dementia*, 0(0), pp. 1-21. doi: 10.1177/1471301214532643.  
Newton, L, and Robinson, L, (2013) 'Assistive technologies to maximise independence in people with dementia'. *InnovAiT*, 6(12), pp. 763–771

Robinson, L., Gibson, G., Newton, L., Pritchard, G., Finch, T., Brittain, K, and Kingston, A, (2013) 'Assistive technologies in caring for the oldest old: a review of current practice and future directions'. *Aging Health*. 9(4), pp. 365-375

**Keywords:** Assistive technology, awareness, dementia, general practitioners

**PS01-20 A CROSS-SECTIONAL COMPARISON OF BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS IN PATIENTS WITH MILD COGNITIVE IMPAIRMENT AND MILD ALZHEIMER'S DISEASE**

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**Objectives:** Neuropsychiatric symptoms (NPS) play an important role throughout the course of cognitive disorders. The presence of neuropsychiatric symptoms (NPS) in dementia predicts unfavorable outcomes such as poor prognosis, high caregiver burden, institutionalization and drug use. Although there is some evidence that NPS are common in dementia, they have received less attention in the prodromal stages, including MCI. NPS may be associated with increased risk of progression to dementia.

**Methods:** In this cross-sectional study 39 patients with MCI (mean age= 80.4 ±4.7) and 45 patients with mild Alzheimer's disease (AD) (mean age=80.7 ±5.1) were recruited in a Geriatric Day Hospital. Cognitive functioning was measured using the Mini Mental State Examination (MMSE; Folstein *et al.*, 1975) and Cambridge Examination for Mental Disorders of the Elderly (CAMCOG-R; Roth, 1986). NPS were assessed with the Neuropsychiatric Inventory Questionnaire (NPI-Q; Kaufer *et al.*, 2000).

**Results:** There was no significant difference between MCI and mild AD for the total score (MCI =10.5 ±8.5; AD =16.2 ±14.6) total score severity (MCI= 4.7 ±3.6; AD =7.4 ±6.3), nor for the presence of NPS (MCI= 2.7 ±1.7; AD =3.6 ±2.7). Only a significant difference between MCI and AD for delusions and aberrant motor behavior, was observed. Both symptoms were more present in AD compared with MCI. Furthermore, no significant correlations between cognition (total score and subscales MMSE and CAMCOG-R) and NPS (NPI-Q total score, NPI-Q score severity, NPI-Q total caregiver burden and total number of BPSD) were observed (all  $p < .05$ ).

**Conclusion:** These findings suggest that NPS are already present in MCI with the same frequency as in mild AD and support the hypothesis that NPS might constitute an important early sign of mild AD, exempt for delusion and aberrant behavior. Further research on NPS in MCI and the predictive value for conversion to AD is needed.

**References:** Folstein, M.F., Folstein, S.E. and McHugh, P.R. (1975). Mini-Mental State: A practical method for grading the cognitive state of patients for clinician. *Journal of Psychiatric Research*, 12, 189-198. doi: 10.1016/0022-3956(75)90026-6.

Kaufer, D.I., Cummings, J.L., Ketchel, P., Smith, V., MacMillan, A., Shelley, T. *et al.* (2000). Validation of the NPI-Q, a brief clinical form of the Neuropsychiatric Inventory. *The Journal Neuropsychiatry & Clinical Neurosciences*, 12, 233-239. doi:10.1176/appi.neuropsych.12.2.233

Roth, M.E. (1986). CAMDEX: a standardised instrument for the diagnosis of mental disorder in the elderly with special reference to the early detection of dementia. *British Journal of Psychiatry*, 149, 698-709.

**Keywords:** BPSD, dementia, Mild cognitive impairment

**PS01-21 MEASURING COGNITIVE CHANGE FOR HEALTHY ELDERLY CONTROLS, MILD COGNITIVE IMPAIRMENT AND ALZHEIMERS'S DEMENTIA: RELIABLE CHANGE INDEX VERSUS REGRESSION BASED INDEX**

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**Introduction:** Progressive episodic memory impairment is a core diagnostic criterion of Alzheimer's disease. Repeated neuropsychological memory assessment is required to recognise this progression. Several statistical methods are available to evaluate deterioration in individual test scores.

**Objectives:** This study compares two of these statistical methods for their usefulness in determining deterioration of test scores on the Visual Association Test (VAT) and the Rey Auditory and Verbal Learning Test (RAVLT). This study aims to determine which statistical method most accurately predicts change in test scores for healthy elderly controls (HC) and MCI patients.

**Methods:** HC (N=24) and Patients (N=25) were tested twice with an interval of four to 15 months. Test-retest-reliabilities and changes scores were calculated from test data of controls. Reliable Changes Indices + Practice Effect (RCI+P.E.-methode; Chelune et al., 1993) and Regression Based Indices (SRB-methode; McSweeney et al., 1993 according to the formula of Crawford & Howell, 1998) were used as change scores. Both indices correct for practice effects. However, the SRB method also corrects for regression-to-mean. Accuracy of the methods was evaluated by classifying controls in unchanged or deteriorated. Based on a normal distribution of change scores, deterioration can occur in 5% of all cases.

**Results:** The VAT and RAVLT-*recognition* were subject to low test-retest-reliabilities ( $r < 0.40$ ); for RAVLT-*immediate recall* and -*delayed recall* reliabilities were high ( $r > 0.70$ ). As expected, maximally 5% of HC deteriorated on all cognitive test measurements according to the SRB-method. According to the RCI-method, these percentages were much higher for tests with high test-retest-reliabilities (resp. 12.5% and 16.7%). Tests with low test-retest-reliabilities showed ceiling effects. Thus, an alternative approach was used, basing the indices for the VAT on test scores of 19 MCI patients (new controls: MCI-C), with a test-retest interval of 1 hour to eliminate deterioration caused by dementia. 5.3% of MCI-C deteriorated according to the SRB-method, while 15.8% deteriorated according to the RCI-method.

**Conclusion:** In both approaches the SRB method was more accurate in predicting deterioration in test scores. Furthermore, this study confirms that ceiling effects are a threat for such indices. We advise to use norm groups with baseline test scores comparable to the research group. This study presents normative data for change scores.

## PS01-22 NATURE AS AN INTERVENTION IN DEMENTIA: FIRST RESULTS OF A QUALITATIVE PILOT STUDY

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**Objectives:** For people with dementia, nature and outdoor spaces can provide a stimulating environment with exposure to light and sensory experiences as well as engagement in pleasant activities. Nature in general is, however, often either not available for nursing home dwellers with dementia or underused despite easy access to it. Outdoor spaces such as gardens and parks are often available for nursing home dwellers and home dwelling persons with dementia, but their use must be further improved.

**Aim:** 1) investigate the views of persons with dementia on the importance of nature and outdoor spaces for their quality of life; 2) create a checklist of what people experience as important for their quality of life in nature and outdoor spaces; 3) determine the content of nature and outdoor spaces interventions aiming at improving the wellbeing of people with dementia and based on what they experience as important for their quality of life in nature; 4) develop a nature/outdoor space wellbeing- intervention for people with dementia, especially for persons who exhibit behaviour that represents unmet needs; 5) pilot test this intervention, investigating possible effects and feasibility.

**Methods:** Focus groups and semi-structured interviews with persons with dementia will be conducted. The intervention will be pilot tested by 15 persons with dementia. Feasibility will also be studied, by interviewing professionals in dementia care.

**Results:** This pilot will yield various results:

- insight into what people with dementia consider important aspects of nature and outdoor spaces;
- a checklist to inventory what people find important in nature for their well-being/quality of life;
- insight into categories of theme interventions regarding nature and outdoor spaces
- insight into facilitators and barriers for implementing nature/outdoor spaces based interventions, to promote future implementation;
- pilot interventions for persons with dementia in different settings (at home, long term care);
- information on feasibility and possible effects of the pilot intervention(s).

**Conclusion:** The study started in June 2014 and will end in May 2015. First results on insight into what people with dementia consider important and relevant aspects of nature and outdoor spaces will be presented.

**Keywords:** nature, outdoor activities, people with dementia, personalised intervention, quality of life

## PS01-23    CONTAINMENT IN THE COMMUNITY

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**Objectives:** The diagnosis and management of personality disorders in older adults raises a number of practical and ethical questions. Anecdotal evidence within a busy Central London older adult community mental health team suggested limitations in the management approach, with a disproportionate impact on both client and staff well-being.

- 1) To establish the prevalence of diagnosed or suspected personality disorder within the team caseload.
- 2) To quantify the time and resources demanded by this client group.
- 3) To assess the personal and professional impact of working with this client group.

**Methods:** Clinicians were asked to identify clients with a diagnosed or suspected personality disorder. Case notes of the resultant sample were reviewed retrospectively to identify the level of service input over a three month period, looking at the frequency and intensity of clinical contact, both within the team and outside agencies and the perceived effectiveness of said contact. Concurrently, staff attitudes towards the burden of care demanded by this client group, the quality of care they were able to provide and the impact on their remaining caseload and personal wellbeing were also surveyed.

**Results:** Of the clients identified, 4% were formally diagnosed with Personality Disorder, despite 76% with suspected traits. Within the study period, 216 home visits were completed, with 84 telephone contacts and 40 letters written. 15 A&E visits and three psychiatric inpatient admissions occurred. Staff survey demonstrated an even split in terms of perceived personal and professional impact of working with this client group. Despite 68% of staff reporting feeling 'somewhat confident' in managing this client group, 50% of staff felt that a coherent clinical approach was lacking, with clear agreement that further clinical support and training would be beneficial.

**Conclusion:** The complexity of diagnosing and managing personality disorders in the older adult population is clearly replicated in our findings. There is a reluctance to diagnose personality disorders in the elderly, which may lead to an underestimation of client needs and inaccurate treatment goals. Furthermore, suboptimal interpretation of maladaptive behaviours predisposes to ineffective containment for both client and professional. In the absence of clear guidelines to inform the management of this unique client group, more work needs to be done to identify cost-effective interventions to provide containment for both clients and professionals.

**Disclosure of Financial Relationships:** I/we have no financial relationships to disclose

**Keywords:** personality disorder

## PS01-25 TIMELY DIAGNOSIS OF DEMENTIA: ARE WE DOING ENOUGH?

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**Objectives:** The benefits of a timely diagnosis of dementia for patients and their families are widely known. Potential harms of making early diagnosis have to be balanced with the harms of not making diagnosis. Following Dementia G8 Summit, there is increasing drive in the UK to improve diagnosis rates around the country and several initiatives have been developed. This study aims to study the patient journey within the local mental health services, to identify any potential problems and suggest changes to improve the diagnosis rates for dementia.

**Methods:** The study was completed in Lincolnshire which is a fourth largest county within the UK. Sample size of 116 clinical electronic notes was analysed using Microsoft Excel to calculate the waiting time period for first assessment and for the final diagnosis. Local Research and development department approval was obtained.

**Results:** The average waiting time for the first assessment (screening) was 6.5 weeks. All the patients were assessed in the specialist clinic and the average the waiting time was 9.5 weeks from the screening. The reasons for this delay included logistic issues (the delay for the neuroimaging, unavailability of the results of investigations), patient related factors (cancellations, did not attend). On occasions, patients were seen directly by the old age psychiatrist following the referral from the primary care and the average waiting time was 16 weeks from their first referral in primary care.

**Conclusion:** This study outlines the potential barriers to the timely diagnosis of dementia within the secondary services. It does not focus on the factors in primary care such as patient factors (stigma), training issues. As we embrace the World Dementia Challenge, this study is ongoing project with regular checks on improvements in line with the national ambition of NHS England. Locally we have introduced various changes to address the problems identified. Initial screening assessment has been made more robust with the involvement of Old age psychiatrist at early stage in supervisory role to avoid any delay in diagnosis. There is more joint working with the primary care and shared care guidance has been revisited. Even though this study portrays only local picture (Lincolnshire) it highlights the 'treatment gap' which we all need to address around the World and joint campaign with public and professionals in increasing awareness for dementia will play a major role.

**Keywords:** None