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PRESIDENT'S MESSAGE – MARY SANO

Dear IPA members,

I want to thank the many IPA members who have played a role since our last newsletter in June to keep IPA strong and to progress toward our mission. The President, the Executive Committee, and the Secretariat have been working on several issues in the past few months. First, we have recommitted ourselves to serving our membership. From our surveys, we know you value the information and knowledge you receive through our multiple communications. These were highlighted at our recent social held at AAIC, with presentations provided by Drs. Dilip Jeste, Editor-in-Chief of our official journal *International Psychogeriatrics*, by our *IPA Bulletin* editor Tzung-Jeng Hwang, and by our digital editor, Maria Lapid. We also know that you value the opportunity to interact and network with your international colleagues, so we offered our well-received reception at the Shedd Aquarium.

Second, members will appreciate the cutting-edge clinical translational science that serves the mental health of older persons, and the upcoming meeting "Sleep and Healthy Aging" is a perfect example of this. Sleep disturbances have been recognized among the behavioral and neuropsychiatric symptoms that most challenge quality of life and mental health, and have both high prevalence and significant negative impact as we age. This promises to be an extraordinary symposium with world experts sharing the podium. We hope you will join us for this and share the opportunity to experience this venue with others.

We know our members want a voice in the important issues facing those who serve patients, and as such, we have reviewed the spring of 2018 French Ministry of Health and Solidarity (HAS) announcement to end reimbursement of four anti-Alzheimer drugs. IPA has prepared a thoughtful response demanding an evidence-based approach that assures that our patients can access the best treatments available without concerns for economic restriction. IPA will continue to respond to threats of service and resource restrictions that disadvantage our patients.



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PRESIDENT'S MESSAGE

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PRESIDENT'S MESSAGE, *continued from page 1*

IPA continues to be a major contributor to the work of treating older persons with behavioral and neuropsychiatric symptoms, and many of our members are key players in this area. In June of 2018, IPA members Drs. Jeffrey Cummings, George Grossberg, and I took part in the New York Academy of Science's symposium entitled "Psychiatric Symptoms in Alzheimer's Disease and Dementia." Held at the NYAS headquarters at 7 World Trade Center, the meeting was opened by Dr. Cummings, who gave a highly integrated view of the history of codifying neuropsychiatric symptoms. Dr. Grossberg provided an overview of the "Neuroanatomic and Neurochemical Substrates of Behavioral Symptoms in Alzheimer's Disease and Implications for Treatment." I spoke on "Measuring Neuropsychiatric Symptoms for Diagnosis and Outcomes." Interest in such metrics comes from both clinical and research efforts, and while tools exist, there are many gaps in our ability to assess and codify these serious problems. These gaps are apparent to many, and we have been approached to address these. The differences between specific types of neuropsychiatric conditions are an important question yet to be addressed. While we have provided a preliminary consensus on a definition of agitation in dementia, conditions such as apathy, depression, psychosis and sleep disturbance may all require clearer understanding of defining criteria, of operationalizing these criteria, and of measuring the severity and mitigation of these symptoms.

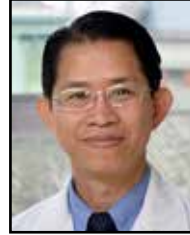
IPA is planning an expert meeting on neuropsychiatric symptoms, which will use our established methods of creating consensus around diagnostic criteria. We hope to bring together key stakeholders, including care providers, families, and patients, in order to create a definition that can focus on symptoms and treatments that are meaningful to patients, not just providers. We look forward to the input from all of our members and our affiliates to address this problem with global input and solutions. I hope you will join this effort and let your voice be heard on this important topic.

Mary Sano
IPA President

EDITOR'S NOTE – TZUNG-JENG HWANG

Under the leadership of President Mary Sano, IPA is actively marching forward. Our most recent highlights include:

- Many IPA opinion leaders attended the Alzheimer's Association International Conference (AAIC) and Alzheimer's Disease International (ADI) meeting in Chicago in July and presented their research work (see article in "Around the World").
- The "Sleep & Healthy Aging" meeting in Hoboken, New Jersey, USA, will be held on 14-15 September 2018.
- The online Argentina Geriatric Psychiatry Program will launch a second round, beginning 1 October 2018, and the Universidad Favaloro is able to provide certification for the online course.
- IPA is co-hosting a workshop with members of the International Association of Physical Therapists working with Older People (IPTOP) in Montreal, Canada in November this year.



You are welcome to join the upcoming activities for learning and networking.

In this issue, there are seven articles, four in "**Research and Practice**", two in "**Around the World**" and one in "**Technology Corner**".

In "**Research and Practice**":

Dr. Damien Gallagher (Canada) provides updates on post-stroke depression (PSD) and concludes that screening for PSD may improve outcomes, but should be combined with processes of care that facilitate effective treatment and follow-up after detection. **Dr. Gillian Stockwell-Smith (Australia)** discusses further improvements that are needed in hospital care of older people. Older people often experience significant deconditioning while in the hospital, but the focus of rapid throughput in acute care tends to deny them a treatment goal of restoration to pre-admission status.

Dr. Karen Reimers (USA) summarizes the risk factors and red flags of undue influence in older adult. This is especially relevant in terms of estate planning. It is important to respect the autonomy of older testators while protecting vulnerable elders from undue influence and financial exploitation.

Finally, **Dr. Laura Valzolgher (Italy)** describes a case of limbic encephalitis, a lesser-known and sometimes under-recognized cause of rapidly progressive dementia.

In "**Around the World**":

Kate Filipiak (USA), the Executive Director of IPA, highlights the IPA social events at the Alzheimer's Association International Conference (AAIC) and

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the Alzheimer's Disease International (ADI) meetings in Chicago. In a second report on AAIC, I further describe IPA's activities and achievements, especially those related to neuropsychiatric symptoms in the elderly.

In "**Technology Corner**":

Dr. Yung-Jen Yang (Taiwan) delineates interesting bone-conducting hearing aids, including wearable and implanted types. These hearing aids may better improve communication for the elderly people.

I want to thank the editors who continue to provide thought-provoking articles and share precious insights with our members. We hope more members can join the editing team and contribute diverse viewpoints to this IPA platform. By doing so, we can further improve the content of the *Bulletin* and make it a useful platform for international communications among IPA members. Please reach us at IPABulletin@ipa-online.org.



Sleep and Healthy Aging
The Neuroscience of Common Clinical Problems

 International Psychogeriatric Association
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14-15 September 2018
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IPA EVENTS

IPA SOCIAL EVENT AT THE ALZHEIMER'S ASSOCIATION INTERNATIONAL CONFERENCE (AAIC) AND THE ALZHEIMER'S DISEASE INTERNATIONAL (ADI) MEETINGS

Kate Filipiak, CAE

Executive Director, International Psychogeriatric Association

IPA recently exhibited at the Alzheimer's Association International Conference (AAIC) and the Alzheimer's Disease International (ADI) meetings in Chicago, Illinois, 21 – 29 July 2018. Thank you to all the IPA members who stopped to say hello and visit.

IPA held a social event at the Shedd Aquarium on Wednesday, 25 July. Over 40 IPA members joined IPA President, Mary Sano, for networking, merriment and fireworks. The fireworks are a famous activity in Chicago and brought lots of fun and excitement to all participants. During the social event, the editors of the *International Psychogeriatrics* (Dr. Dilip Jeste), *IPA Bulletin* (Dr. Tzung-Jeng Hwang), and IPA website (Dr. Maria Lapid) talked about the current status of each publication and what is planned next to move forward. All of them are making good efforts to enhance publication quality and attract more people to join the IPA. Of note, Dr. Dilip Jeste mentioned how he is working to shorten the decision-making time, increase the rejection rate and enhance the impact factor. Many members exchanged their views on how to further improve the quality of IPA's publications and activities.

IPA also announced the dates and place for the 2019 Congress, 4-7 September in Santiago de Compostela, Spain. The city is famous for its origin in the shrine of Saint James

the Great (now the Cathedral of Santiago de Compostela), which is the destination of a leading Catholic pilgrimage route (the Way of St. James). Therefore, the 2019 Congress is expected to be rich not only cognitively but also socially and spiritually. Please check the IPA website for further updates.



POST STROKE DEPRESSION: AMERICAN HEART ASSOCIATION SCIENTIFIC STATEMENT AND UPDATE ON SCREENING TOOLS.

Damien Gallagher MB, MD, MRCPsych, FRCPC
Sunnybrook Health Sciences Centre, Toronto, Canada

Key highlights:

- The American Heart Association scientific statement reviews the recent literature and reports that approximately one in three stroke survivors will have Post Stroke Depression (PSD) during the first year, with prevalence dropping after one year. PSD results in worse functional outcomes and increased mortality, and is predicted by history of depression, cognitive impairment & stroke severity.
- With regard to screening & treatment, they note that a number of screening studies in primary care were not associated with improvements in depression, but that studies using a collaborative care approach did improve outcomes.
- They conclude that screening for PSD may improve outcomes *but should be combined* with processes of care that facilitate effective treatment and follow up after detection.
- It is unclear which is the best screening tool for PSD, but in a more recent study, investigators compared two yes/no screening questions (“Whooley questions”) to the PHQ2, PHQ9 & CESD. The shortened two-question screen had the highest sensitivity (89%) but lowest specificity (66%). The authors concluded that “Whooley questions” are a quick and sensitive screen for PSD, although a greater number of follow up interviews will be required to exclude false positives.

Scientific Statement from the American Heart Association:

In 2017 the American Heart Association released their first scientific statement on Post Stroke Depression (PSD), in which they summarize evidence to date on epidemiology, screening and management options. They note that PSD occurs in approximately one in three stroke survivors with highest prevalence in the first year following stroke (largely constant at 33% throughout first year) and a small drop after one year to approximately 25%.¹ They describe neurobiological and psychosocial risk factors noting that the most consistent predictors of PSD have been physical disability, stroke severity, history of depression and cognitive impairment. PSD is associated with worse functional outcomes and increased mortality following stroke. They note that several studies, although these are of varying methodological quality, indicate that both antidepressant medication and psychosocial interventions can effectively treat PSD. There is also evidence to support use of antidepressant medication and psychosocial interventions

to prevent PSD, but further studies are needed in more representative samples of stroke survivors to determine the optimal timing and duration of treatment. They consider the value of screening and note that although previous guidelines recommend routine screening for PSD, these were not based upon strong RCT evidence showing that screening improves outcomes. They cite a number of studies in primary care that have demonstrated little if any benefit of screening for PSD. Importantly, they note that when screening is combined with collaborative care interventions (using evidence based protocols for treatment, improved communication between primary care providers and mental health professionals with structured follow-up), improved outcomes have been demonstrated primarily in non-stroke populations, with fewer such studies conducted in stroke survivors. They conclude that screening for PSD may improve outcomes “provided that processes are in place to assure accurate diagnosis, timely and effective treatment, and follow-up.”

POST STROKE DEPRESSION, *continued on next page*

POST STROKE DEPRESSION, *continued from page 6*

Update on screening tools: The scientific statement goes on to review the utility of different screening tools for PSD and concludes that the optimal screening tool for PSD remains unclear. They note that diagnosis of PSD can often be difficult because of confounding stroke related symptoms, such as apathy, aphasia or emotional lability. Several scales such as the CESD, PHQ9 and HDRS have demonstrated utility, but they report that these studies have limitations. In a more recent study published in May 2018, investigators address this question by comparing four screening tools for PSD in 147 participants (mean age 69) with ischemic heart disease and self-reported stroke from The Heart and Soul Study.² The Heart and Soul Study followed adults with stable coronary heart disease over 15 years to determine the association between psychosocial factors and cardiovascular health outcomes. They examine four screening instruments for PSD and compared these to a diagnostic interview for depression validated according to DSM criteria. They compare the 10-item form of the CES-D, the PHQ-9, the PHQ-2 and the so-called “Whooley questions.” The “Whooley questions” are two shortened yes/no questions derived from the PHQ-2. The two questions are: “during the past month, have you often been bothered by feeling down, depressed, or hopeless?” and “During the past month, have you often been bothered

by little interest or pleasure in doing things?” An answer of “yes” to either question is considered a positive result. The authors found that 24% of the sample had major depression and that the “Whooley questions” demonstrated the highest sensitivity (89%) but lowest specificity (66%). The PHQ9, using a cut point of ≥ 10 , was least sensitive (51%) but most specific (87%), while all four measures had similar areas under the curve. Limitations of this study include the fact that stroke was ascertained by self-report, and only ambulatory patients were included limiting generalizability. The authors conclude that the “Whooley questions” are a quick and sensitive screen for PSD, although a greater number of follow-up interviews will be required to exclude false positives.

For further reading:

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UNDUE INFLUENCE IN OLDER ADULTS: RISK FACTORS AND RED FLAGS

Karen Reimers, MD

Department of Psychiatry, University of Minnesota, United States

Key highlights:

- Undue influence involves the substitution of a person's wishes with the wishes of the influencer.
- There is no universal definition of undue influence. It is a complex concept that often involves coercion and personal control.
- Risk factors for undue influence include cognitive impairment, special (i.e. trusting, confidential) relationship with the influencer, family conflict, emotional vulnerability, psychiatric conditions, medical comorbidities.
- Red flags for undue influence include frailty and dependence, sequestration and isolation, influencer's active participation in making the will, inconsistencies between prior intentions and the new will, and unusual benefit to influencer under new will.
- Increasing numbers of older individuals around the globe are vulnerable to undue influence.
- In 2009, the IPA Task Force on Wills and Undue Influence published consensus guidelines for expert assessment of risk factors for undue influence in older people.
- Geriatric psychiatrists must respect the autonomy of older testators (people making their wills) while protecting them from undue influence and financial exploitation.

Undue influence refers to the substitution of a person's wishes or free will with someone else's wishes. It is a legal construct, defined by the courts. The approach to undue influence varies in international jurisdictions and even within countries. Geriatric psychiatrists around the world, particularly in countries with common law systems influenced by the Anglo-Saxon tradition, may be asked to give an opinion about undue influence after assessing impairments and factors making an older individual vulnerable. Questions about undue influence can arise in a variety of medical or legal contexts: primarily wills, but also contracts including power of attorney. Expert evaluation for undue influence is frequently performed retrospectively after the testator, or person making the will, is deceased.

Undue influence is a complex concept. At a basic level, it involves the substitution of a person's wishes with the wishes of the influencer. It is distinguished from "due" influence (natural favoritism or devotion to certain heirs) in that undue influence involves coercion (often over an extended period of time, and it may be concealed or indirect) and personal

control over the testator. There is rarely direct evidence of undue influence, so courts generally make this determination based on circumstantial evidence, by relying on inference. Undue influence is a distinct concept from fraud (e.g. deception, trickery, forgery) and duress (e.g. direct threats of harm, blackmail).

Unlike testamentary capacity, which has relatively well defined and widely accepted criteria (*Banks vs. Goodfellow*), there is no clear consensus on the precise definition of undue influence. Several sets of criteria have been developed to define and conceptualize undue influence, but none is in universal use.

In 2009, the IPA Task Force on Wills and Undue Influence published consensus guidelines for expert assessment of risk factors for undue influence in older people. Since that important publication, we continue to face rapidly increasing numbers of older people with vulnerability to undue influence around the globe, and increasing numbers of will contest cases in the courts. The field continues to develop,

UNDUE INFLUENCE IN OLDER ADULTS, *continued on next page*

UNDUE INFLUENCE IN OLDER ADULTS, *continued from page 8*

and the IPA Capacity Shared Interest Forum continues its work on undue influence and related questions.

This article briefly summarizes key risk factors and red flags guiding the evaluation of undue influence in older people, based on criteria from the published literature.

RISK FACTORS FOR UNDUE INFLUENCE

Cognitive impairment

Dementia is an important factor rendering older adults potentially vulnerable to undue influence. An older person with cognitive impairment may be easy to manipulate, requiring little pressure to bring about the desired result. In disputed cases, the level of dementia may be relatively mild or subtle. The more severe the cognitive impairment, the more susceptible and suggestible the older person may be.

Special relationship with the influencer

Individuals in a position of trust, especially those with close and frequent contact such as those living with the older person, have increased opportunity to exercise undue influence. A confidential relationship with the older person provides a potential opportunity to control testamentary changes. There is frequently a power differential. Relationships that may pose particular risk include family members, friends, caregivers, suitors/romantic partners, and trusted professionals.

Family conflict

An older wealthy person may be drawn into family conflict. Family disagreements are often emotionally distressing to the older person, exacerbating problems with judgment and decision making.

Emotional vulnerability

Of many possible emotional factors, bereavement and grief associated with the loss of a spouse is particularly likely to render an older person vulnerable. Influencers may manipulate the older person emotionally by withholding affection, threatening or promising to keep the person out of residential care, or pressuring on cultural or religious grounds.

Loneliness, sexual bargaining, and end-of-life issues can also be at play.

Psychiatric conditions

Disorders including depression, paranoia, anxiety and substance abuse may interfere with financial decision making, impair judgment in personal relationships, and compound isolation, dependency and cognitive problems.

Physical morbidities, additive effects of multiple health problems

Older people with medical problems may be more likely to suffer from isolation and communication difficulties. Impairment in vision, hearing and mobility can contribute. If multiple medical problems are present, the compounding effects can render the individual highly dependent and vulnerable.

RED FLAGS FOR UNDUE INFLUENCE

Testator is weakened, frail and dependent

Overall, the weaker the testator, the more vulnerable to undue influence. In such cases, even a small amount of pressure on the older person can produce the influencer's desired result. When several individual risk factors (illness, dementia, emotional problems, etc.) are present in an older testator, the combination is a potential red flag.

Sequestration and isolation of the testator

The influencer may inhibit outside contact with the testator, limiting telephone calls, barring the house, and generally interfering in the testator's relationship with previously trusted family members and friends, possibly "bad mouthing" them or invoking fear. This may be exacerbated by physical or communication difficulties. The influencer may manipulate the testator and distort the truth by limiting the free flow of information.

Influencer actively participates in making the will

There may be suspicious circumstances surrounding making of the will and signs that the influencer is the one actively instigating the changes. The influencer may be the one

UNDUE INFLUENCE IN OLDER ADULTS, *continued on next page*

UNDUE INFLUENCE IN OLDER ADULTS, *continued from page 9*

finding and retaining the services of the attorney, providing transportation and personally accompanying the testator to the lawyer's office. The lawyer may be well known to the influencer.

New will is inconsistent with testator's prior stated intentions

If the contents of the new will are not in keeping with the older person's previous longstanding wishes, especially if there is a radical change in the pattern of distribution of the assets, it is a potential red flag.

Unusual benefit to influencer under new will

The contents of the new will may benefit the influencer financially, or the new distribution may reflect the influencer's aim to get revenge on others (perhaps prior beneficiaries) or to fulfil a particular financial or other agenda through the effected changes.

Conclusion

Estate planning is dynamic, and older people may change their minds about their testamentary disposition. It is important to respect the autonomy of older testators while protecting vulnerable elders from undue influence and financial exploitation. In cases where there is a question of undue influence, the risk factors and red flags listed here can be a helpful starting point for the psychiatric expert. None of

those factors alone is proof of undue influence, but if several or all of the factors are present, an expert investigation into undue influence may well be warranted.

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LIMBIC ENCEPHALITIS: A LESSER-KNOWN AND SOMETIMES UNDER-RECOGNISED CAUSE OF RAPIDLY PROGRESSIVE DEMENTIA.

Laura Valzolgher

Memory Clinic, Geriatric Department, Bolzano Hospital, Italy

Diagnostic criteria for definite autoimmune limbic encephalitis (Graus F et al. *Lancet Neurol* 2016). All four of the following criteria must be met (if one of the first three criteria is not met, diagnosis of definite limbic encephalitis can be made only with the detection of antibodies against cell-surface, synaptic or onconeural proteins):

- Subacute onset (rapid progression of <3 months) of working memory deficits (short-term memory loss) seizures or psychiatric symptoms suggesting involvement of the limbic system.
- Bilateral brain abnormalities on T2 weighted fluid attenuated inversion recovery MRI highly restricted to the medial temporal lobes
- At least one of the following :
 - CSF pleocytosis
 - EEG with epileptic or slow wave activity involving the temporal lobes
- Reasonable exclusion of alternative causes

Background:

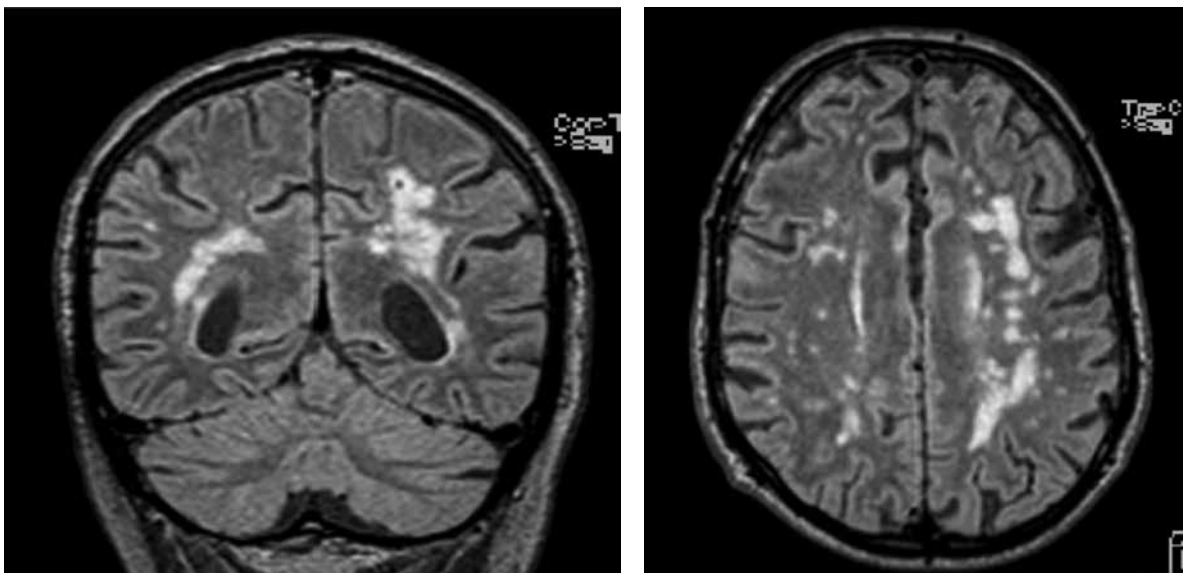
The diagnostic approach of patients referring for initial memory impairment and neurocognitive decline includes a complete series of clinical, biochemical, neuroradiological, and biomarkers evaluations in order to differentiate potentially reversible and treatable conditions from other chronic neurodegenerative diseases, such as Alzheimer's, Lewy body, Parkinson's, and vascular dementia. In particular, time of onset and progression of symptoms should guide clinicians to rule out acute and rapidly progressive forms of dementia, such as Creutzfeldt Jakob disease or infective, inflammatory, and autoimmune encephalitis. Among the latter, limbic encephalitis is a lesser-known inflammatory condition localized to structures of the limbic system presenting with mood and behavioral changes, short-term memory impairment and cognitive dysfunction.

Case Presentation:

A 76-year old man with a medical history of hypertension and dyslipidemia was referred to ambulatory neuropsychological assessment because of recent onset of subjective short-term memory loss, which did not interfere with daily living activities. The brain CT scan at first evaluation showed signs

of chronic vascular encephalopathy. Neuropsychological assessment showed uncertainty in orientation to time, as well as low but still normal results in learning profile and language comprehension, whereas a normal performance was observed in all other functions (attention, processing speed, reasoning, and problem-solving, spatial, and language production). Four months after initial assessment the patient was admitted to the neurologic department for acute confusional state. This time Magnetic Resonance Imaging (MRI) of the brain was performed demonstrating areas of high signal changes in the medial temporal lobes bilaterally on FLAIR sequences (see images). Additional tests for rapidly progressive dementia were performed, including paraneoplastic and anti-neuronal antibodies, screening for viral meningoencephalitis and cerebrospinal fluid (CSF) essay. The findings were suggestive for the diagnosis of limbic encephalitis, and the patient was treated with high-dose parenteral corticosteroids, followed by a tapering oral dose over a few months. He also underwent a tumor screening, which gave negative results. His condition ameliorated during treatment until full recovery.

LIMBIC ENCEPHALITIS, *continued on next page*



Figures: MRI in patient with limbic encephalitis showing in axial and coronal FLAIR images signal abnormalities in the bilateral mesial temporal lobes.

Discussion and Rapid Overview of Limbic Encephalitis:

Limbic encephalitis is a lesser-known acute or subacute inflammatory condition localized to structures of the limbic system (hippocampus, amygdala, hypothalamus, cingulate gyrus, limbic cortex) that might be of paraneoplastic origin but also due to other autoimmune conditions.

Typical symptoms of limbic encephalitis beside short-term memory impairment and cognitive dysfunction include focal seizures with impaired awareness, mood and behavioral changes and occasionally hypothalamic dysfunction (hyperthermia, somnolence, endocrine abnormalities). Symptoms tend to evolve over days or weeks, but subacute presentations over months have also been described. Most frequently associated neoplasms are: lung cancer (commonly small cell lung cancer), seminoma and other testicular tumors, thymoma, breast cancer, and Hodgkin lymphoma. Neurological symptoms typically precede the tumor discovery. Diagnostic workup includes typical electroencephalography (EEG), magnetic resonance imaging (MRI), serum and cerebrospinal fluid (CSF) assay.

Typical EEG findings include slowing or epileptiform activity that is maximal in the temporal regions. MRI may show on

T2 fluid attenuated inversion recovery FLAIR sequences hyperintensity in the mesial temporal lobes. Autoantibodies varies according to tumor type and are to be found in serum and CSF. Autoimmune encephalitis is associated with antibodies to neuronal cell surface/synaptic proteins.

Diagnostic criteria for definite autoimmune limbic encephalitis are shown in the highlight box.

Treatment and Outcome

Treatment options include immunosuppression and tumor resection for paraneoplastic forms, while if untreated, limbic encephalitis can lead to progressive neurologic deterioration and death. Spontaneous recovery, however, has also been described. First-line immunosuppressive treatment includes parenteral corticosteroids, intravenous immunoglobulin, and plasma exchange, according to individual case. As a second-line therapy, other immunosuppressive agents such as Rituximab and Cyclophosphamide may be considered.

There is a variable but favorable response to treatment for autoimmune encephalitis, ranging from complete recovery to permanent neurologic sequelae and death, whereas the prognosis for paraneoplastic forms depends on the underlying tumor.

LIMBIC ENCEPHALITIS, *continued from page 12*



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Laura Valzolgher, MD, works at the Memory Clinic at the Geriatric Department of Bolzano Hospital, Italy. She is currently completing a Master of Science Degree in Psychogeriatrics at University La Sapienza Rome.

IMPROVEMENTS REQUIRED IN HOSPITAL CARE OF OLDER PEOPLE

Dr. Gillian Stockwell-Smith, RN, MN, MAP (Hons), PhD

Menzies Health Institute Queensland, Griffith University, Queensland, Australia

Key highlights:

- Most high-income countries have a large and rapidly increasing older population, but acute hospital services have been slow to acknowledge and respond to the complex care needs of older people.
- Older people often experience significant deconditioning while in hospital, but the focus of rapid throughput in acute care tends to deny them a treatment goal of restoration to pre-admission status.
- Respect and knowledge are lacking in the care of older people in hospital, particularly in relation to people with dementia.
- Initiatives to improve hospital care of older people exist and current demographic trends indicate that we need to focus on putting them into action sooner rather than later.

Most high-income countries have a large and rapidly increasing older population [1]. Ageing is accompanied by a broad range of psychosocial changes and an increasing risk of physical and cognitive decline. The risk of having more than one health condition (multiple morbidity) increases with age [2], and older people have higher health service utilisation (particularly inpatient care) [3]. However, acute hospital services have been slow to acknowledge and respond to the changing demographic and resulting complex care needs of older people [4]. Quality of care is high on the agenda of hospital authorities worldwide, but hospitals can be dangerous places for older people [5]. Older people have a high risk of injury (falls) and secondary infections (delirium, pneumonia, urinary infections) whilst in hospital [6]. As a consequence they often experience significant deconditioning (decline in physical and cognitive capacity) [5]. Older people require time to fully recover after an acute episode of illness or injury, but the focus of rapid throughput in acute care tends to deny them a treatment goal of restoration to pre-admission status. Shorter hospital stays also mean that decisions about older patients' capacity to return home are often made when they are still unwell and/or vulnerable [7].

Health professionals attitudes towards older patients have become less positive over time [8]. Attitudes affect the quality of care provided, as reflected in findings from many studies on the care and experiences of older people in hospital. Older people with longer than expected hospital stays are frequently seen as unnecessarily occupying hospital beds [9]. They are referred to as 'bed blockers,' regardless of whether the delay is due to hospital factors (delayed diagnostic tests or investigations) or additional care needs [9]. People with dementia are commonly perceived as a source of stress and frustration due to their complex care needs and behaviours [10]. Nurses report that they receive very little education about dementia and lack the skills required to manage patients with dementia [10]. Family members often play a significant role in caring for older people at home, particularly those with dementia, but feel excluded when the person is admitted to hospital [10]. They express frustration with both the quality of hospital care and staff attitudes towards their own knowledge and experience [4].

It appears that respect and knowledge are lacking in the care of older people in hospital, particularly people with dementia [4]. Greater attention to fundamental nursing care can prevent functional and cognitive decline, and may

improve the quality of care of older people in hospital, as well as discharge outcomes [11]. Relational approaches to care that are respectful and inclusive may also underpin more positive experiences of acute health care for older people and their carers [4]. Adopting a comprehensive approach to carer engagement in the hospital care of older people has been suggested as a means of improving care delivery and continuity [12]. Initiatives such as The Dementia Friendly Hospital Initiative Education Programme have shown significant improvement in hospital staff attitudes and practices [13]. It is apparent that initiatives to improve hospital care of older people exist, and current demographic trends indicate that we need to focus on putting them into action sooner rather than later.

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Profile



Dr. Stockwell-Smith is a registered nurse and works with older people in hospital, community and residential aged care settings in the United Kingdom and Australia for over thirty years. She is currently a research fellow in sub-acute and aged care nursing with Griffith University and Gold Coast Hospital and Health Service. g.stockwell-smith@griffith.edu.au .

INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION (IPA) AND SOCIAL MEDIA

Social media is now the way for people to communicate and interact online. Initially for personal use, it has evolved to include different businesses and organizations. It has become a fast and popular way to distribute information, opportunities and connect the member around the world in an instant.

What makes it “social” is its content, which can include conversations, commentary, and other user-generated annotations and engagement interactions.

Publishing content has become exponentially simpler over the last several years, which has helped skyrocket the use of social media.

Nowadays, it is unthinkable for an organization to not participate in social media, interacting directly with its members. IPA has had a growing role in social media, with Twitter and Facebook accounts. IPA has four main goals for our social media accounts:

- Maintain IPA’s worldwide reputation as diverse & cutting edge
- Expand IPA’s engagement with global geriatric mental health professionals
- Increase awareness of IPA’s events, programs & publications
- Highlight content on the IPA website & *International Psychogeriatrics Journal*

For those of us who are not so “tech savvy,” this article aims to help you understand the basic of Facebook and Twitter, how to connect with the IPA community online, and how to share and create new content.

FACEBOOK



Facebook can be accessed from a large range of devices with Internet connectivity, such as desktop computers, laptops, tablets, and smartphones. After registering, users can create a customized profile indicating their name, occupation, schools attended, and so on. Users can add other users as “Friends”, exchange messages, post status

updates, share photos, videos and links, use various software applications (“apps”), and receive notifications of other users’ activity. Additionally, users may join common-interest user groups organized by workplace, school, hobbies or other topics, and categorize their friends into lists such as “People From Work” or “Close Friends”. Additionally, users can report or block unpleasant people.

How do I create a Facebook account?

To create a Facebook account:

1. Go to www.facebook.com/r.php. (or download the app on your mobile)
2. Enter your name, email or mobile phone number, password, date of birth and gender.
3. Click [Create an Account](#).
4. To finish creating your account, you need to [confirm your email or mobile phone number](#).

To follow IPA just search for <https://www.facebook.com/ipaonline/> in your browser once you have a facebook account and click on “like” You will then see new posts on your Facebook homepage (or “newsfeed”).

TWITTER



Twitter is an online news and social networking service, on which users post and interact with messages known as “tweets”. Tweets were originally restricted to 140 characters, but on November 7, 2017, this limit was doubled for all languages except Japanese, Korean, and Chinese. Registered users can post tweets, but those who are unregistered can only read them. Users access Twitter through its website interface, or mobile device app.

How do I create a Twitter account?

1. Go to <http://twitter.com> and find the sign up box, or go directly to <https://twitter.com/signup>. (or download the app on your phone)
2. You will be guided through our sign up experience and prompted to enter information such as your name and email address.
3. Please note that in order to verify your phone number,

IPA AND SOCIAL MEDIA, *continued on next page*

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we will send you an SMS text message with a code. You may also request a voice call to verify your phone number. Enter the verification code in the box provided. Learn more about having a [phone number associated with your account](#).

- Once you sign up for an account, you can select a username (usernames are unique identifiers on Twitter). We'll tell you if the username you want is available.
- Learn how to [customize settings](#) for your new account.

To follow IPA, just search [IPA Online](#), and click on follow. You'll then see our updates in your Twitter feed.

Enjoy!



Dr. Tomás León R. is a Psychiatrist of the Memory Unit at Hospital del Salvador, Santiago, Chile.

A REPORT ON ALZHEIMER'S ASSOCIATION INTERNATIONAL CONFERENCE (AAIC) 2018

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Department of Psychiatry, National Taiwan University Hospital, Taiwan



The 2018 Alzheimer's Association International Conference (AAIC) was held at McCormick Place, Chicago in July this year. It is the world's largest meeting about dementia, with the main goal of advancing science, ranging from basic research to personalized care. Like last year, there were more than 90 sessions, more than 1,500 posters and 6 preconference workshops. A total of more than 5000 participants, from at least 70 countries around the world, attended the meeting. The IPA also took this opportunity to set up a booth, communicating with vast numbers of participants from related fields.

One of the Professional Interest Areas (PIAs) that may be most interesting to IPA members is the Neuropsychiatric

Syndrome PIA. Several members are the opinion leaders of the PIA, such as Prof. Sano, Cummings, Mintzer etc. This year, the Neuropsychiatric Syndrome PIA hosted a variety of activities to discuss the measurement and treatment of agitation, apathy, psychosis and other related issues. The new concept of mild behavioral impairment still attracted many researchers and clinicians to learn how this mild form of neurobehavioral symptoms can help early identify potential problems and lead to early intervention. The 2014 IPA criteria of agitation was frequently mentioned during these activities, showing the important contribution of IPA to this field. Echoing this trend of development, our IPA President, Prof. Mary Sano, published a key paper ("Identifying better outcome measures to improve treatment of agitation in dementia: a report from the EU/US/CTAD Task Force") in 2018 with six major recommendations, including operationalized agitation criteria, combining clinician- and caregiver-derived outcomes, using global ratings to define clinically meaningful effect, improving the accuracy of caregiver reports, employing emerging technologies to collect real-time data, utilizing innovative trial design, and increasing the use of biomarkers. Critical questions include how to define these specific conditions, how to select instruments to measure

A REPORT ON AAIC 2018, *continued on next page*

AROUND THE WORLD

A REPORT ON AAIC 2018, *continued from page 15*

symptoms, and whether the best approach is to define, diagnose and treat symptom clusters or comprehensive conditions, etc.



In fact, IPA has been a leader in developing definition and advancing understanding of NPS in AD and other dementias. The groundbreaking concept of Behavioral and Psychological Symptoms of Dementia (BPSD) was proposed by IPA experts after consensus meetings in 1994. Over the years, expert consensus meetings have been conducted about BPSD (twice), Lewy Bodies, Vascular Dementia, Mild Cognitive Impairment, etc. Currently, IPA plans to develop definitions of and metrics for the full range of neuropsychiatric symptoms, which include agitation, mood, psychosis and sleep.

There are two things worthy of mentioning related to IPA members. Prof. Jeff Cummings received the Lifetime Achievement Award, and Prof. Henry Brodaty gave a plenary speech titled “Psychosocial Research in Dementia: Past, Present and Future.” Both are leaders in research field of dementia, and we are very proud of them.



BONE-CONDUCTION HEARING AIDS FOR BETTER COMMUNICATION IN THE ELDERLY

Yung-Jen Yang, MD, MSc.

Member of directors, Taiwanese Society of Geriatric Psychiatry, Taiwan

Key points:

- Hearing loss in older individuals is a common and important issue. While many interventions have been developed, their efficacy and effectiveness remain uncertain.
- Most devices act upon the air-conducting route, but there are many advantages to targeting the bone-conducting route. Personal sound amplification products (PSAPs) are wearable bone-conduction

hearing aids, which are not subject to medical device regulations and thus the most easily acquired, nicknamed “over the counter hearing aids.” Implanted bone-conduction hearing aids vary in complexity, including bone-anchored hearing aids (BAHAs), cochlear implants, implantable middle ear hearing devices, and auditory brainstem implants.



Figure 1. Styles of wearable hearing aids (from <https://www.nidcd.nih.gov/health/age-related-hearing-loss>)

Communication is a key element in healthcare and social services, and especially important in the care services for the elderly because of the ageing effects on the auditory system. There are various factors that may cause hearing loss in older people, including long-term noise exposure, poorly controlled hypertension and diabetes mellitus, medications, some diseases and even the unexplainable ageing effects. These environmental and medical conditions contribute in common to the damages on the apparatuses in our inner, mid and even outer ears. According to the previous studies, hearing loss of mixed causes has been the leading type in the elderly.

There have been several approaches developed to solve these problems, including written aids, lip reading or speech reading, conservative types of hearing aids or headphones, and more invasively implanted hearing aids. After exploring the literature, there are a few systematic reviews that specifically address this issue, but the efficacies and effectiveness of these devices remain uncertain. Although hearing aids are not a novel invention in human history, those that improve hearing by



Figure 2. wearable personal sound amplification product (PSAP)

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acting on the air-conduction route remain most prevalent, and seem easily available in the market. However, based upon clinical experience and primary studies, devices that take advantages of the bone-conductive route appear appealing. In this brief column, I will specifically focus on hearing aid devices with bone-conduction properties.

According to the US Food and Drug Administration, "hearing aids" refer to any wearable instrument or device designed for, offered for the purpose of, or represented as aiding persons with or compensating for impaired hearing (21 CFR 801.420, US FDA). I will roughly divide them into wearable and implanted aids; implanted aids frequently require surgical procedures to implant.

The first category of bone-conductive hearing aids, the wearable type, can be easily acquired from the market when it is not classified as a medical device, or accessed with some kind of medical evidence/prescription depending on the conditions or purposes (21 CFR 801.421, US FDA). The most accessible wearable bone-conduction hearing aids for the elderly are also classified as personal sound amplification products (PSAPs), which are not subject to medical device regulations. These PSAPs are nicknamed as "OTC hearing aids" and can be purchased at various stores and even online.

The other category of bone-conductive hearing aids, the implanted type, requires surgical implantation of conductors or sound generators that adhere to the bone. Bone-anchored hearing aids (BAHAs) are the simplest, cochlear implants and implantable middle ear hearing devices more complex, and auditory brainstem implants the most delicate, only performed after a thorough evaluation and licence.

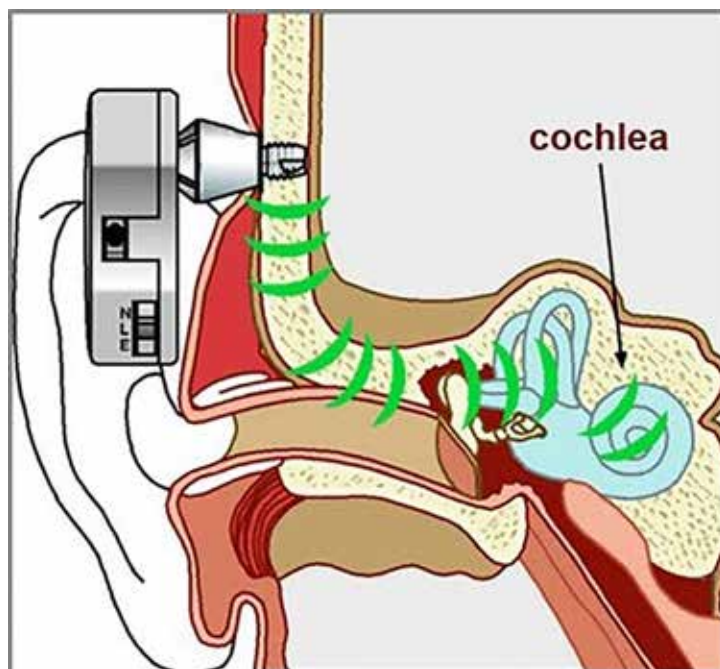


Figure 3. Implanted bone-anchored hearing aid (BAHA) (from http://www.otosurgery.org/BAHA_overview.htm)

In the practice of geriatric psychiatry, better communications with the patients prompt to better quality of service, avoiding faults, and reducing the wastes of unnecessary medical sources. These factors urged the frontline practitioners to prepare supportive tools whenever there to be barriers in communication. In my empirical experience so far, even a PSAP at hand can dramatically concur the communication barriers related with mixed-type hearing loss which is quite common in the elderly.

Dr. Yang is a psychogeriatrician in Taiwan, and is also the founding Secretary General of Taiwanese Society of Geriatric Psychiatry. He is interested in the new innovations, technologies and trials in healthcare, and has been well trained for evidence-based medicine in the UK to be capable of critically appraising the information.

IPA MEETINGS & COLLABORATIONS

In collaboration with the Institute of Cognitive Neurology (INECO) Foundation and Universidad Favaloro in Buenos Aires, Argentina, the IPA will launch the second round of Spanish-language online courses to provide initial training in Psychogeriatrics to address growing needs in Latin America.

The second round of courses will launch online beginning 1 October 2018.

- The course has been developed with the “online” mode so as to be accessible to working professionals who may have limited time.
- It includes six 1-hour modules.
- Attendees have access to a weekly forum to exchange views with teachers and colleagues.
- There is a final exam online and attendees who pass the course will receive a certificate of accreditation from the IPA, INECO, and the Universidad Favaloro.



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SCHOLARSHIPS ONCE AGAIN AVAILABLE

Rome 2018

Nursing Home Research International Working Group LONG TERM CARE RESEARCH

13-14 September 2018 • Roma, Italy

IPA Programs Include:

- International Psychogeriatric Association Symposium on People with Young Onset Dementia
- Crisis situations concerning severe challenging behavior of nursing home residents with dementia: a symposium of IPA's BPSD Special Interest Forum
- Complex interventions focusing on managing of challenging behavior in NH residents with dementia, in Germany, Norway and the Netherlands. Lessons for the challenge of implementation

<https://www.ipa-online.org/nhltc>



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IPA MEETINGS & COLLABORATIONS

UPCOMING IPA MEETINGS

Sleep and Healthy Aging

14-15 September 2018

[Sleep and Healthy Aging](#)

Hoboken, New Jersey, US

IPA/SEPG International Congress

4-7 September 2019

Santiago de Compostela, Spain

COLLABORATIVE MEETINGS

13-14 September 2018

[Nursing Home Research International Working Group](#)

[Long Term Care Research](#)

Rome, Italy

ADDRESSING THE IMPACT OF COGNITIVE FRAILTY AND DEMENTIA ON THE REHABILITATION OF OLDER ADULTS

IPA is excited to partner with the Canadian Physiotherapy Association (CPA) and the International Physical Therapists for Older Adults (IPTOP) [for this new one-day workshop](#). Geared towards physiotherapists and other allied health professionals working with older adults, the programs will focus on a critical and increasingly important aspect of frailty that significantly impacts the rehabilitation potential of older adults—age-associated mental/cognitive disorders and dementia.

- **Date:** 1 November 2018
- **Location:** Canadian Physiotherapy Association Congress; Montreal, Quebec
- **Program Host:** International Physical Therapists for Older Adults (IPTOP)
- **Program collaborators:** International Psychogeriatric Association (IPA) and Canadian Physiotherapy Association (CPA) / Seniors' Health Division
- **Intended audience:** Physiotherapists, and other allied health professionals working with older adults

IPA PRESENTERS

David Conn MB, BCh, BAO, FRCPC

Baycrest Centre for Geriatric Care

"The Impact of Dementia on Rehabilitation"

Kiran Rabheru MD, CCFP, FRCP, DABPN

University of Ottawa

"Neuropsychiatric Contributors to Frailty & Rehabilitation Potential"

IPTOP/ CPA PRESENTERS

Hans Hobbelen, PT, PhD

Hanze University of Applied Sciences, Groningen, the Netherlands

"Overview of frailty and varying viewpoints in the literature"

Susan Hunter, PT, PhD

University of Western Ontario

"Balance and gait and their interaction with cognitive decline"

