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## PRESIDENT'S MESSAGE – MARY SANO

Dear Colleagues,

I have had an opportunity to visit our affiliates and other colleagues around the globe and through these visits, I am reminded of the importance of the work to serve our members who serve the mental health and wellness needs of patients.

In December, I had the honor to be invited to Naples to the XIV Brain Aging Conference sponsored by the Associazione Italoamericana Geriatrica.

This meeting entitled "*Psychogeriatrics: Between neurobiology, clinic, relationship. A medicine for our time*" showcased the best of our knowledge about caring for aging populations. The meeting's Chair, Dr. Vincenzo Canonico opened the meeting and the President of the Association, Dr. Marco Trabucchi presided over the first day's sessions. We heard from Paola Barbarino, CEO of Alzheimer's Disease International (ADI) who reminded the audience of the global nature and magnitude of the epidemic of Alzheimer's disease. Dr. Diego De Leo spoke on loneliness in the elderly, a topic which has received global attention. Some have suggested social isolation, a growing problem that contributes to loneliness, pointing out that mobility and economic limitations cause this isolation.

This trip was followed by an invitation to join the Alzheimer Association in their satellite meeting in Bengaluru where I was impressed to hear the sophistication of our Indian colleagues in identifying cognitive loss and dementia. One highlight of the meeting was to hear about the social networks in place to serve individuals who live in remote areas of the country. Public health service delivered via nurses and other community workers shares the burden of identifying and managing diseases.

Finally, I was invited to a meeting organized by Drs. Ilan Gonen and William Reichman, the president-elect of IPA. Entitled "*Long Term Care: Aging in Place*", this event brought together disruptive thinkers from aging advocacy, aging residency and healthcare, health technology and health economics to provide transformative ideas on best practices of aging health and living opportunities. The session opened with a keynote by Dr. Nir Barzilai who described the science of aging and potential to define an indication in which interventions might interrupt both the aging process and the diseases which accompany aging. With that potential, the meeting



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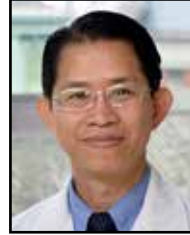
faced the challenges of living longer and living better. The meeting provided us with economic challenges to longer life, reminding us that wrap-around services to provide for both health and living would be required.

One challenge is that currently institutions and governments compartmentalize services and the monies that pay for them. For example, housing and health care budgets are separate entities but housing can provide better compliance with health management. The audience was challenged to think about broader systems in which payors could cross current barriers which currently delineate between health services and social services, despite the fact that one may not be helpful if the other is ignored. For example, transitioning to home after hospital might require home adaptation in the home setting that is not supported by current health services. Models of financing that permit support across these traditionally distinct sectors are needed to maximize the quality of life for an aging person.

Another challenge is addressing the need to remain connected, related and meaningfully engaged with others as we age. These are certainly the areas in which our IPA members have the commitment and expertise. IPA members across disciplines strive to ensure that older persons have the opportunity to experience mental health and wellness and this experience often identifies a need for socialization and supervision. These needs may be difficult to address in long term care setting, which may be remote from family and friends. Even models of "aging in place" may limit access to the range of services and opportunities that are needed to ensure that clients have the opportunity to experience the fullness of health, wellness and even satisfaction in the lives they lead.

Another theme of the Long Term Care meeting was the use of technologies across many aspects of healthy aging. In particular, many technologies exist to help overcome barriers of distance or immobility, that lead to isolation and that can exacerbate loneliness. Descriptions of prototypes for connecting people across distances and generations were provided, and case studies of technologies to enhance health care communication and social interaction were discussed. At the individual level, however, limited income and resources may hinder uptake. Also cognitive and physical challenges to learn and adopt technology may impede maximal use and stigma associated with these challenges may make it difficult for individuals to ask for assistance. On a global level, it was noted that developing countries with limited infrastructure may not be able to support the systems needed to ensure connectivity or the education to use such capacities. However, the potential is great and the work of overcoming these barriers was made transparent. I hope IPA and its members will contribute to these topics, creating innovative solutions to identifying methods that advance aging mental health and wellness to be delivered over the "long term" in any setting, permitting aging persons to age in the best place for them.

### EDITOR'S NOTE – TZUNG-JENG HWANG



There is an old saying that morning is the best startup of a day and spring is the best startup of a year. Later this month, IPA will convene an expert consensus meeting in Lisbon, Portugal to define psychosis in Alzheimer's disease and other dementias. IPA has been a leader in defining and developing a better understanding of the neuropsychiatric symptoms in dementia. Over the years, expert consensus meetings have been conducted in Behavioral and Psychological Symptoms of Dementia (BPSD) twice, Lewy Bodies, Vascular Dementia, and Mild Cognitive Impairment, etc. The 2019 Joint International Congress will be held from 31 August – 3 September 2019, in Santiago de Compostela, Spain. Due to its popularity, the third round of the online Spanish course in psychogeriatrics will be held on 6 May 2019. In addition, IPA leaders and Secretariat will attend the AD/PD, AAIC, and AAGP meetings to have more exchanges with experts and colleagues in this field. Through these efforts and other endeavors, IPA is continuing its mission of creating better mental health for the elderly.

I am happy that there has been a gradual increase in the number of submitted articles and reports. In this issue, there are nine articles, five in **"Research and Practice,"** three in **"Around the World,"** and one in **"Technology Corner."**

#### In **Research and Practice**:

Dr. Mark Rapoport (Canada) addresses an interesting and important issue: how to face the challenge of increasing prescriptions of hypnotosedative medications? He reviews three different papers and points out that in Quebec, Canada an educational brochure directed at both patients using sedative-hypnotics and their physicians led almost half of the sample to stop their medications. Mengelers et al. (Netherlands) introduce the use of involuntary treatment in people with cognitive impairment living at home in the Netherlands. They also emphasize the development of a multi-component approach to provide caregivers the necessary knowledge and tools to prevent involuntary treatment. Drs. Diego de Leo and Marco Trabucchi (Italy) discuss the infrequently explored issue of "loneliness", describing confusion among three terms: being alone, social isolation, and suffering from loneliness. To raise public awareness, the Italian Association of Psychogeriatrics pronounced 15 November as a national day to combat loneliness. Dr. Laura Valzolgher (Italy) describes cerebral amyloid angiopathy (CAA) as an important cause of primary lobar intracerebral hemorrhage and vascular dementia in older adults. Finally, Dr. Karen Reimers (US) briefly presents the advocacy and policy issues in geriatric mental health, ranging from driving capacity, testamentary and financial capacity, and guardianship, to end of life issues.

EDITOR'S NOTE, *continued on next page*

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### In "Around the World":

Dr. Águeda Rojo (Spain) reports the Spanish Psychogeriatric Society has started a nation-wide training program in the care and intervention of patients with dementia. Similarly, Dr. Liang (Taiwan) highlights the 2018 annual meeting of the Hong Kong Psychogeriatric Association and Tripartite Psychogeriatric meeting on 24 November 2018. More than 70 geriatric psychiatrists, geriatricians, and healthcare professionals from Hong Kong, Taiwan, and Mainland China, enthusiastically participated in the meeting. Dr. Clarissa Giebel (UK) updates us on the issue of health inequality and reports the results of a large Household Health Survey in the North West of England (one of the most deprived regions in England). She reminds us how health inequalities can affect all types of healthcare, including dementia care and medication.

In "Technology Corner", Dr. Yung-Jen Yang (Taiwan) briefly explains virtual reality, augmented reality and mixed reality in geriatric mental health care. He introduces the project "A Walk through Dementia" developed by the Alzheimer's Research UK (ARUK). In that project, virtual reality technology was implemented as a practical tool to aid the understanding of dementia. Interesting information from several websites is introduced.

These research and local reports from around the world show the diverse and innovative development in geriatric mental health. I cordially invite you to submit your article to share thoughts and experiences with us! You can reach us at [IPABulletin@ipa-online.org](mailto:IPABulletin@ipa-online.org).

# Save the Date

## IPA/SEPG Joint International Congress

 31 AUGUST - 3 SEPTEMBER 2019 

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Better Mental Health for Older People



Sociedad Española  
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### ALZHEIMER'S ASSOCIATION ANNOUNCES ITS INTERNATIONAL RESEARCH GRANT PROGRAM FOR THE 2019 JUNE PROGRAM.

Application procedures and key dates are now available, see the [IPA website](#) for full descriptions of each grant type listed and links to apply.



Letters of intent (LOI) must be received by 8 March 2019, 5:00 PM EST.

#### GRANTS AVAILABLE INCLUDE:

1. Alzheimer's Association Research Grant (AARG)
2. Alzheimer's Association Research Grant to Promote Diversity (AARG-D)
3. Alzheimer's Association Research Grant - New to the Field (AARG-NTF)
4. Alzheimer's Association Research Grant to Promote Diversity - New to the Field (AARG-D-NTF)
5. Alzheimer's Association Research Fellowship (AARF)
6. Alzheimer's Association Research Fellowship to Promote Diversity (AARF-D)
7. Alzheimer's Association Clinician Scientist Fellowship (AACSF)
8. Alzheimer's Association Clinician Scientist Fellowship to Promote Diversity (AACSF-D)
9. The Zenith Fellows Award Program (Zenith)

#### 2019 JUNE PROGRAM KEY DATES:

- LOI is now open
- **LOI deadline –8 March 2019, 5:00 PM Eastern**
- Application deadline for those invited to submit a full application – April 29, 2019, 5:00 PM Eastern
- Award notification – 30 August 2019

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

The third round of courses will begin 6 May 2019.

- The course has been developed with the "online" mode so as to be accessible to working professionals who may have limited time.
- This course is presented in Spanish.
- 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.
- All course participants receive one year free IPA membership



#### SCHOLARSHIPS NOW AVAILABLE

### BENZODIAZEPINES: THE CHALLENGE AND THE OPPORTUNITY

Mark Rapoport, MD, FRCPC

Professor of Psychiatry, University of Toronto; Staff Psychiatrist, Sunnybrook Health Sciences Centre

#### Key highlights:

- Nationally-representative US data indicates that sedative-hypnotic prescriptions for older adults doubled between 2003 and 2015.
- Sedative-hypnotics were self-reported to be used by 8.3% of the older adult population, and were prescribed in 25% of ambulatory care visits for those with insomnia.
- An educational brochure directed at patients using sedative-hypnotics and at their physicians in Quebec, Canada led almost half of the sample to stop their medications, and three-quarters of those who initiated a taper were successful at six months.

Although benzodiazepines continue to be commonly prescribed among older adults, a practical easily-scalable intervention can lead to successful discontinuation of these often dangerous medications at a community-wide level.

Maust et al., (American Journal of Geriatric Psychiatry 2019) conducted the first large-scale American estimate of prescription medication and over-the-counter agents specifically used for sleep in older adults since 1979. The authors found that 35.4% of just over 1,000 community-dwelling older adults between the ages of 65 and 80 endorsed using a sleep product. The most common type was an over-the-counter sleep aid such as “Tylenol PM” or “Benadryl,” followed by herbal or natural sleep aids. Prescription sleep medication was endorsed by 8.3% of the sample (benzodiazepines and z-drugs), and prescription pain medication by 5.0%, specifically for sleep. Of the full sample more than two-thirds endorsed any sleep difficulty and less than half had discussed ways to improve sleep with their physician. Poor perceived physical health was a significant predictor of prescription pain or sleep medication used specifically for sleep, but other demographic factors and perceived mental health were not significant predictors.

Agarwal and Landon (JAMA Open 2019) published another study of nationally representative American data. This study used pharmacy data from ambulatory visits and did not rely on self-report as the study by Maust et al. did, but no data

was provided about sleep complaints or non-prescription sleep products. Agarwal and Landon used a serial cross sectional approach to compare benzodiazepine prescription prevalence in 27.6 million ambulatory care visits in 2003 and 62.6 million visits in 2015. The authors found that benzodiazepine visit rates doubled from approximately 3.8% to 7.4% of visits. The doubling of rates was also true among adults age 65 and over, with the unadjusted estimated benzodiazepine visit rate of approximately 3.1% in 2003 and approximately 6.4% in 2015. Among ambulatory visits for insomnia, the benzodiazepine visit rate was about one-quarter in 2015, with no significant change from 2003, although no such data were provided for the older adults sub-sample.

These are important studies for those of us working with older adults because in both cases, the authors used nationally representative samples, and examined the use of these agents, specifically for sleep rather than for other indications such as anxiety or low mood. In the Maust et al. study, it is difficult to rely on the estimated prevalence of sleep related symptoms, as respondents were asked about how many nights they had sleeping problems, but 67.7% of those who reported sleep difficulty included those who had such a problem only one night per week. The authors did not explore the daytime impact of sleep difficulties, which may have further led to an over-estimation of sleep difficulties.

BENZODIAZEPINES: THE CHALLENGE AND THE OPPORTUNITY, *continued on next page*

Similarly, the rates of use of sleep products include those who reported only occasional use, and frequency and duration of use were not reported in this manuscript, which relied on self-report of use of such products.

In the Agarwal and Landon study, objective prescription data and a larger sample led to more precise estimates, but their delegation of indication for the prescription relied on electronic medical record data of variable quality. Nonetheless, we can conclude from these studies that among nationally representative American samples of older adults, the majority have sleep complaints at least once a week of varying severity, 8.3% self-report receiving a prescription for sleeping medication specifically for sleep, benzodiazepines prescriptions are doubling for older adults, and about one quarter of ambulatory visits for insomnia (all ages) lead to a benzodiazepine prescription. Other research has indicated that benzodiazepine use is often chronic, despite known risks, minimal benefits in the short-term for insomnia, and stopping these medications can be very challenging.

Martin et al. (2018), randomized community pharmacies in Quebec, Canada to a pharmacist-led educational intervention targeted at patients and their physicians, or to treatment as usual. The primary outcome was discontinuation of prescriptions for inappropriate medications at six months following the intervention. The medications targeted were sedative-hypnotics, first generation antihistamines, glyburide, and nonsteroidal anti-inflammatory drugs, for patients age 65 years and older who had filled a prescription for one of these medications for at least three consecutive months. Four hundred eighty-nine patients were enrolled from 69 pharmacies, of whom 89% completed the trial. Patients on antipsychotics, cholinesterase inhibitors, or with a Mini-mental Status Examination (MMSE) less than 24 were ineligible for participation. The intervention included educational material for patients comprising a drug-specific brochure with information about why the medication may be inappropriate, potential alternatives for treatment, and for benzodiazepines, a visual tapering

protocol. There was also an educational material package for physicians in the form of an evidence-based pharmaceutical opinion including the rationale for why de-prescribing was recommended, evidence about drug harms, credible sources of recommendations, potential safer therapeutic alternatives, and personalized participant data. A robust effect was found, with 43% of those in the intervention group no longer filling a prescription for one of these potentially inappropriate medications compared with 12% in the control group (a number needed to treat of 3.2). For sedative hypnotics, 43.2% of patients had stopped by six months compared with 9.0% in the control group (number needed to treat of 2.9). Although 38% of sedative-hypnotic users reported withdrawal symptoms during the taper, 75% of users who initiated tapering successfully completed the protocol.

The magnitude of this effect was greater than in an earlier study by the same group using only the educational brochure, and not material sent to the prescribing physician, with a number needed to treat of five, and a 54% success rate in tapering sedative-hypnotics. Although the main limitation of this study is the relatively short six month follow-up, the principal finding is that a low tech educational brochure to patients and their physicians has a large effect in reducing these prescriptions, off-setting at least to some degree the rising prescription prevalence of this potentially harmful medication.

### For further reading:

*Maust, D.T., Solway, E.S., Clark, S.J., Kirch, M., Singer, D.C., Malani, P. Prescription and nonprescription sleep product use among older adults in the United States. American Journal of Geriatric Psychiatry 2019, 27 (1): 32–41. PMID: 30409547*

*Agarwal, S.D., Landon, B.E. Patterns in outpatient benzodiazepine prescribing in the United States. JAMA Open 2019, 2(1):e187399. PMID: 30681713.*

*Martin, P., Tambllyn, R., Benedetti, A., Ahmed, S., Tannenbaum, C. Effect of a pharmacist-led educational intervention on inappropriate medication prescriptions in older adults. The D-PRESCRIBE randomized clinical trial. JAMA 2018, 320(18): 1889–1898.*

BENZODIAZEPINES: THE CHALLENGE AND THE OPPORTUNITY, *continued from page 7*

### Cited in Above Work:

Tannenbaum, C., Martin, P., Tamblin, R., Benedetti, A., Ahmed, S. Reduction of inappropriate benzodiazepine prescriptions among older adults through direct patient education: The EMPOWER cluster randomized trial. *JAMA internal medicine* 2014, 174 (6), 890-898. PMID: 24733354



Dr. Mark Rapoport is a professor in the geriatric psychiatry division of the department of psychiatry at the University

of Toronto, a clinical scientist at Sunnybrook Health Sciences Centre, and past President of the Canadian Academy of Geriatric Psychiatry. His main areas of research are traumatic brain injury in the elderly and the risk of motor vehicle collisions associated with neurological and psychiatric diseases and their treatments. After serving as an Assistant Editor, Dr. Rapoport became the Deputy Editor for the Research and Practice section of the IPA Bulletin in 2016. He regularly writes on recent advances in the field.

## THE USE OF INVOLUNTARY TREATMENT IN PEOPLE WITH COGNITIVE IMPAIRMENT LIVING AT HOME

Angela MHJ Mengelers, MSc<sup>1</sup>; Vincent Moermans, MSc, RN<sup>1,2</sup>; Michel HC Bleijlevens, PhD<sup>1</sup>; Hilde Verbeek, PhD<sup>1</sup>; Liz Capezuti, PhD<sup>3</sup>; Koen Milisen, PhD, RN<sup>4,5</sup>; Jan PH Hamers, PhD<sup>1</sup>

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### Key highlights:

- Involuntary treatment is used in 39% of the people with cognitive impairment receiving home care in the Netherlands and in 51% of the people with cognitive impairment receiving home care in Belgium
- Risk factors for involuntary treatment include cognitive impairment, higher ADL dependency and higher perceived caregiver burden by the informal caregiver
- Informal caregivers and general practitioners are more accepting of involuntary treatment use, find non-consensual care and physical restraints less restrictive and feel more comfortable using these measures, compared with nursing staff and other health care professionals

With the ageing population, the number of people with cognitive impairment is increasing, worldwide. The majority of older people live at home and wish to live at home as long as possible, in an environment that feels familiar and safe. In most Western countries the government supports this by an active 'ageing in place' policy. However, allowing older people to remain at home longer is challenging, since they often

require complex and extensive assistance from informal and professional caregivers, and increased social support (Hamers *et al.*, 2016).

Providing care for people with cognitive impairments can be very challenging. How do we create a balance between providing quality of care and safety while maintaining dignity and autonomy? Should we lock the door to prevent people

THE USE OF INVOLUNTARY TREATMENT IN PEOPLE WITH COGNITIVE IMPAIRMENT LIVING AT HOME, *continued on next page*



from going outside, or respect their freedom with the risk that they get lost? Distressed by these dilemmas, caregivers may choose quick but potentially harmful solutions that can negatively affect the person's quality of life, such as forcing people to eat, administering psychotropic medication, or using physical restraints (Hamers *et al.*, 2016; Mengelers *et al.*, 2019; Moermans *et al.*, 2018). Care to which the client resists and/or does not provide consent for are defined as involuntary treatment (Hamers *et al.*, 2016). Involuntary treatment includes 1) physical restraints, defined as any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to his/her body by the use of any method that is attached or adjacent to a person's body and that he/she cannot control or remove easily (Bleijlevens *et al.*, 2016), 2) psychotropic medication, defined as substances that act directly on the central nervous system, affecting mood, cognition and behavior, and 3) non-consensual care, care that restricts the patient's freedom of living (e.g. locking in a room, use of electronic surveillance and forced administration of food or hygiene) (Hamers *et al.*, 2016).

In the Netherlands, regulations to prevent and reduce involuntary treatment such as the "Care and Coercion" act are being developed. This act regulates the right of people with intellectual disabilities and people with psychogeriatric disorders and will go into effect in January 2020. The starting point is that involuntary treatment and coercive measures are not appropriate methods of care for older or disabled people. A multi-disciplinary step-by-step plan must be followed to stimulate voluntary care and indicate possible alternative interventions.

Although the literature on involuntary treatment in home care is scarce, recent studies indicated that involuntary treatment is common practice in home care (Hamers *et al.*, 2016; Moermans *et al.*, 2018). A questionnaire was developed to assess involuntary treatment use and possible associated factors in two cross-sectional studies in the Netherlands and Belgium. District nurses and dementia case managers completed the questionnaire for every selected client with

cognitive impairment within their caseload. A dementia case manager is an independent professional caregiver, often with a nursing background who coordinates care for people with (suspected) dementia and their caregiver. Results indicate that involuntary treatment was used in 39% of the people with cognitive impairment who were also receiving home care in the Netherlands and 51% in Belgium (Hamers *et al.*, 2016; Moermans *et al.*, 2018). In both countries non-consensual care was the most common type of involuntary treatment (79% and 73%, respectively), followed by psychotropic medication (41% and 43%, respectively). Physical restraints were the least common measures (7% and 38%, respectively). Involuntary treatment was more likely to be applied in people with higher activities of daily living (ADL) dependency and poorer cognitive abilities. Besides, involuntary treatment was associated with higher perceived caregiver burden by informal caregivers.

Informal caregivers play an important role in the request and application of involuntary treatment. In more than 70% of the cases of involuntary treatment use, it was requested by informal caregivers, both in the Netherlands and Belgium. Nursing staff requested the use of involuntary treatment in 33% of the cases in the Netherlands and 43% in Belgium. Involuntary treatment was applied mostly by nurses in Belgium (81%) and informal caregivers in the Netherlands (72%) (Hamers *et al.*, 2016; Moermans *et al.*, 2018). Some caregivers might not be aware that they provide involuntary treatment, such as locking a door when leaving the house or hiding medication (Mengelers *et al.*, 2019). Also, some types of involuntary treatment such as providing medication or assisting with feeding might be considered as necessary interventions and there is a lack of consensus regarding what constitutes "good" care (Mengelers *et al.*, 2019). Common reasons for caregivers to use involuntary treatment include, their belief that those measures prevent harm or wandering, or postpone nursing home admission. Others use these measures to respite from other caregiving activities. (Scheepmans *et al.*, 2014). However it may be questioned if one can justify the use of involuntary treatment for these

reasons since some types of involuntary treatment are not used correctly, used for too long or for the wrong reason, and have shown to be ineffective. Besides it is associated with negative effects including aggression, agitation and even injuries (Moermans *et al.*, 2018).

To prevent involuntary treatment in home care it is important to foster dialogue between formal and informal caregivers regarding the decision-making process and possible alternative interventions. The study of Mengelers *et al.* (2019) indicates that informal caregivers and general practitioners may have more positive attitudes towards the use of involuntary treatment compared with nursing staff and other health care professionals (e.g. physical therapist, psychologists), indicating that they are more accepting of involuntary treatment. Attitudes of informal caregivers living with dementia patients did not differ from attitudes of those not living with dementia patients. Acceptance of involuntary treatment is associated with perceived burden: caregivers who sometimes, often or always experience burden were more accepting of involuntary treatment than caregivers who never or rarely experienced burden. In line with these findings, we also found that informal caregivers and general practitioners perceived non-consensual care and physical restraints less restrictive for people with dementia, and indicated feeling more comfortable when using these measures than nursing staff. No differences were seen in perceived restrictiveness of, and discomfort in, using psychotropic medication between formal and informal caregivers.

Future studies should provide insight into why involuntary treatment is applied and how this process is experienced by both formal and informal caregivers. In addition, it is important to study what the challenges and needs are of caregivers providing care for people with cognitive impairment who live at home. Based on this input, researchers (Heale, 2019) emphasize the development of a multi-factorial approach to provide professional and informal caregivers the necessary knowledge and tools to prevent involuntary treatment, by adapting a client-oriented care approach and the use of alternatives.

### For further reading:

Bleijlevens, M. H., Wagner, L. M., Capezuti, E. and Hamers, J. P. (2016). *Physical Restraints: Consensus of a Research Definition Using a Modified Delphi Technique. Journal of the American Geriatrics Society, 64, 2307-2310.*

Hamers, J. P., Bleijlevens, M. H., Gulpers, M. J. and Verbeek, H. (2016). *Behind Closed Doors: Involuntary Treatment in Care of Persons with Cognitive Impairment at Home in the Netherlands. Journal of the American Geriatrics Society, 64, 354-358.*

Heale, R. (2019). *Better support and education is imperative to bolster informal at-home carers of people with cognitive impairment and reduce incidences of involuntary treatment of older adults in their homes. Evidence-based nursing, ebnurs-2018-103028.*

Mengelers, A. M., Bleijlevens, M. H., Verbeek, H., Capezuti, E., Tan, F. E. and Hamers, J. P. (2019). *Professional and family caregivers' attitudes towards involuntary treatment in community-dwelling people with dementia. Journal of advanced nursing, 75, 96-107.*

Moermans, V. R., Bleijlevens, M. H., Verbeek, H., Tan, F. E., Milisen, K. and Hamers, J. P. (2018). *The use of involuntary treatment among older adults with cognitive impairment receiving nursing care at home: A cross-sectional study. International journal of nursing studies, 88, 135-142.*

Scheepmans, K., de Casterlé, B. D., Paquay, L., Van Gansbeke, H., Boonen, S. and Milisen, K. (2014). *Restraint use in home care: a qualitative study from a nursing perspective. BMC geriatrics, 14, 17.*



Angela Mengelers works as a PhD student at the department of Health Services Research at Maastricht University. Her research focuses on involuntary treatment in home care and aims to develop a multi-component intervention to prevent and/or decrease involuntary treatment use at home.



Vincent Moermans works as a PhD student at the department of Health Services Research at Maastricht University and for a home health care organization, the White Yellow Cross in Belgium. His research focuses on the prevention and reduction of involuntary treatment at home.

## LONELINESS FOR MEDICAL ATTENTION

Diego de Leo, MD, PhD, DSc<sup>1</sup>, Marco Trabucchi, MD<sup>2</sup>

<sup>1</sup>Vice-President and <sup>2</sup>President, Italian Psychogeriatric Association

### Key highlights:

- Loneliness may be more about the quality of relationships rather than the quantity of relationships
- Loneliness exacerbates feelings of social isolation, depression, and other chronic diseases
- More research is necessary to improve our understanding how loneliness affects geriatric mental health.

Loneliness leaps to public attention as a result of the Theresa May government's initiative to establish a ministry to combat it. The need arises from the observation that in the British Kingdom the Cox Commission ends up counting over nine million individuals who feel always or frequently lonely. It is the lack of relationships, contacts and information opportunities that make this population a group of individuals particularly exposed to morbidity of all kinds and, therefore exposes the United Kingdom to very high health costs, calculated by consumer cooperatives (CO-OP) in around 3.5 billion pounds a year. Tracey Crouch, former undersecretary for sport and civil society, interprets for the first time, the role of minister in the fight against loneliness; Mims Davies replaced it last November.

Many other governments formally set up initiatives to help lonely citizens. These initiatives do not refer only to those who live in remote locations but also to the many citizens who populate metropolitan realities and who may work in crowded offices and yet suffer from loneliness. So, the loneliness we refer to here is not synonymous with social isolation or living alone. It is up to a psychologist of Italian origins, John Cacioppo, to have clearly provided an operative definition of loneliness useful for clinical research and planning of interventions. Cacioppo - also known as **Dr. Loneliness** for his nearly 30-year research activity on the subject at the University of Chicago, believes that the most relevant concept of loneliness describes a negative emotional state experienced when there is a difference between the relationships one would like to possess and

those that one perceives to have in reality (Cacioppo and Cacioppo, 2014). The unpleasant sensations of loneliness are therefore subjective. Loneliness is not about the amount of time spent with other people or alone; loneliness is more related to the quality of relationships than to their quantity. The 'lonely' persons feel that they are not understood by others and therefore believe they cannot have satisfactory relationships with anyone.

### LONELINESS BY GENDER AND AGE

There are no precise indications of difference in prevalence of loneliness for men and women. It is likely that women, living longer than men, may suffer more; however, it is known that women are better able to create social networks and to derive useful information from them to improve quality of life and obtain psychological support in case of need. Men are generally less likely to reveal their loneliness because of cultural and gender differences in the expression of emotions.

In all western societies, older adults suffer the most from loneliness. In Italy, the Istituto Nazionale di Statistica (ISTAT) 2018 report paints a particularly alarming picture: about 40% of those age 75 and older do not have a friend or relative to turn to in case of need. Only one elderly person in four has a social network made up of relatives and friends and/or neighbors. In a country with a negative birth rate and with an increasing number of elderly people, the figure detected by ISTAT acquires the dimension of a real public emergency.

With age, relational opportunities diminish. Various factors contribute to creating the basis for isolation: loss of the social

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LONELINESS FOR MEDICAL ATTENTION, *continued from page 11*

role, progressive disengagement from the active world, diminished economic resources, mourning, diminished physical capacity, sensory losses, chronic illnesses, and so on. It is clear that physical limitations and the concentration of diseases end up affecting the possibilities of access to the active world. The inability to share one's thoughts and experiences of life with others in connection with the perception of no longer being socially interesting, reinforces the experiences of invisibility and worsens the sense of belonging. This is why the elderly, especially in the most advanced age, end up suffering more than others the consequences of loneliness.

### LONELINESS AS A RISK FACTOR

The effects of loneliness are not limited to subjective experiences. It is now clear that loneliness is an important risk factor for many problems of physical health, from fragmented sleep and decreased cardiac output to the onset of dementia. The lack of social connections poses a risk of premature death that is very similar to well-known pre-mortality factors such as smoking and obesity (Cacioppo, 2008). These data began to emerge into the scientific limelight in the late '70s, with the publication of the findings of the longitudinal study of the county of Alameda in California. Berkman and Syme (1979), studying about 7,000 people, discovered that men and women "disconnected from others" were about three times more likely to die during the study (which lasted nine years) than people with strong social ties.

A few years later (1984), Ruberman and Associates, studying 2,320 male subjects who survived a myocardial infarction, found that people with stronger social connections had much greater odds of staying alive in the three years following the attack of those who could not enjoy the availability of satisfactory social relationships. By conducting a meta-analysis of published studies, Holt-Lunstad et al. (2010) confirmed that people who have strong social interactions are 50% more likely to live longer than those with few or absent social ties.

Perissinotto et al. (2012), using a sample of 1,600 respondents, showed that 43% of the elderly lived in a lonely condition. Six

years after the first interview, the researchers found that those who reported a condition of loneliness had a risk of dying 45% higher than others; moreover, these people - with the sharpening of the perception of their own isolation - were facing a deterioration in the quality of life and a reduction in personal autonomy.

The association between loneliness and suicide has long been known (De Leo et al., 2013), to the point that the feeling of not belonging to any environment (thwarted belongingness) represents a pivotal concept in the interpersonal theory of suicide (Van Orden et al. 2010). An Australian study of elderly people killed by suicide and based on the use of psychological autopsy (De Leo et al., 2013) dramatically highlighted that among the subjects who died by suicide, the presence of disregarded psychological support (from family and/or friends) was recorded almost constantly. It should be noted that the lack of social support was significantly more important than the lack of practical help from the same sources (De Leo et al., 2013).

### LONELINESS AND FRAGILITY

Loss of social role, diminution of physical vigor and sexual function, loss of senses, diminution of personal autonomy and self-esteem, chronic diseases, narrowing of the existential horizon, are among the most common conditions that make people more fragile with age. The lack of contacts represents a limit to help seeking and obtaining information useful for obtaining the best level of assistance and therefore of psycho-physical health. In elderly subjects, loneliness ends up in association with a significant reduction in quality of life, as well as in life expectancy. In fact, important longitudinal studies such as the Grant Study (Vaillant, 2002) and the 90+ Study (Lee et al., 2016) clearly demonstrate how the life span is significantly longer due to the richness of relational life.

Other devastating consequences of loneliness concern the onset of dementia. The Amsterdam Study of the Elderly (AMSTEL) (Holwerda et al., 2012) first showed that the feeling of being lonely, rather than being actually alone, was associated with an increased risk of dementia in old age and could be considered an important risk factor, regardless of

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vascular disease, depression and other confounding factors. The same study underlined how experiences of loneliness could signal a prodromal stage of dementia. A group of researchers from Boston (Donovan et al., 2016) analyzed the association between the level of perceived loneliness and the presence of beta-amyloid plaques, a protein that aggregates in the brains of patients with Alzheimer's disease (AD), in cognitively healthy people. Analyzing a group of 79 elders, the authors observed that people who were positive for beta-amyloid (those in whose brain the protein aggregated) felt 7.5 times more lonely than those who were beta-amyloid negative. The English Longitudinal Study on Aging (ELSA) confirmed these findings in a sample of 6,677 subjects aged between 52 and 90 years. Rafnsson et al. (2017), from this study, showed that individuals who lived alone had a risk of dementia from 35% to 44% higher than those who had a significant relationship. In other words, this fact implied that having an intense (not necessarily marital) relationship gave about 60% less chance of developing dementia.

Loneliness can be so intolerable that people may be tempted to commit crimes in order to stop it, despite the risk of going to prison. The news was taken by agencies around the world. In Japan there have been several cases of elderly people who would have been arrested so as not to continue living alone. After all, Japan is notoriously the country in which people often live and die alone. It is also the country that has made the word 'hikikomori' internationally known, which literally means to isolate oneself. Today, it is a term used above all to refer to younger people who choose to retire from social life, often taking refuge in extreme forms of isolation. The phenomenon seems to represent a form of reaction to social pressure (especially in a competitive society like Japan's) that pushes towards self-fulfillment and personal success from the beginning of adolescence.

### CONCLUSIONS

The study of loneliness is still in its early stages. As a 'transversal' element, which concerns different fields such as geriatrics, sociology, psychiatry and psychiatry (but many other disciplines could be added), the study of loneliness risks

suffering from the schematic borders of funding agencies to slow down any development. The literature data available are still few; among them, there is still much confusion between apparently overlapping concepts such as social isolation, being alone and suffering from loneliness.

Raising awareness of the problem of loneliness is certainly important. To this end, the Board of Directors of the Italian Association of Psychogeriatrics (AIP), in the session of 26 January 2018, in Modena, unanimously approved the establishment of a national day to combat the loneliness of the elderly. It is timely and important this initiative of the AIP, which led her to identify November 15th as a date to raise awareness among public opinion and health workers on the need for appropriate interventions to counteract the seriousness of the phenomenon and its many repercussions. It would be important that the International Psychogeriatric Association and other national realities followed the call for a collaborative and shared effort to counteract loneliness. It would be a small step towards a great goal.

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## CEREBRAL AMYLOID ANGIOPATHY: A LESSER-KNOWN CAUSE OF COGNITIVE DECLINE

Laura Valzolgher, MD

Memory Clinic, Hospital of Bolzano, Italy

### Key highlights:

- Cerebral amyloid angiopathy (CAA) is an important cause of primary lobar intracerebral hemorrhage in older adults
- It is usually asymptomatic, but the incidence of symptomatic CAA is age-related; it is unusual in individuals younger than 55 years.
- CAA can occur as a sporadic disorder, with or without associated Alzheimer disease, or as a familial syndrome.
- CAA is characterized by the deposition of amyloid beta peptides in small to medium-sized blood vessels of the brain and leptomeninges
- Transient neurologic symptoms, subacute cognitive decline, seizures, are possible neurological manifestation of CAA
- CAA and Alzheimer disease frequently co-exist. CAA may also be associated with a vascular dementia

**INTRODUCTION:** Cerebral amyloid angiopathy (CAA) is the second most common type of cerebral small vessel disease, which is characterized by amyloid beta peptide deposits within small-to-medium blood vessels of leptomeninges and cerebral cortex. It can be sporadic, or associated with

Alzheimer disease, or as a part of certain familial syndromes. The incidence is age-dependent and the prevalence on autopsic studies reaches 12.1 % over the age of 85. No predilection for gender is shown. While the definitive diagnosis is only by postmortem examination of the brain,

CEREBRAL AMYLOID ANGIOPATHY: A LESSER-KNOWN CAUSE OF COGNITIVE DECLINE, *continued on next page*

Boston diagnostic criteria for CAA are used to make the diagnosis of “probable CAA” during life, according to MRI and tissue findings (*for the full table of Boston criteria see the link below Linn et al. Neurology 2010*).

**PATHOGENESIS:** Vascular amyloid deposits in sporadic CAA are similar to the material comprising senile plaques in Alzheimer disease. Vascular rupture and bleeding in CAA seems to be a multistep process, which begins with the deposition of amyloid beta-peptide in the vascular wall and leads to the cracking of the wall. The factors that promote amyloid beta-peptide deposition in CAA are not well known. However, it has been observed that patients carrying the APOE epsilon 2 (e2) or epsilon 4 (e4) alleles could be at greater risk for CAA-related hemorrhage than those with only the common APOE epsilon 3 (e3) allele.

**CLINICAL SYMPTOMS:** CAA is often asymptomatic, and is sometimes discovered by incidental microhemorrhages or hemosiderosis on MRI. However, in older adults it can present with transient neurological disorders, inflammatory leukoencephalopathy, and cognitive impairment, which are due to lobar intracerebral hemorrhages. “Lobar” refers to the cortex and subcortical white matter, which are the typical locations of CAA-related hemorrhages. It also reflects the underlying distribution of the vascular amyloid deposits in the cortical vessels, while white matter, deep gray matter, and the brainstem are often spared. CAA-related hemorrhages are also more likely to arise in posterior brain regions. The leptomeningeal vessels are extensively affected with CAA, and superficial CAA-related bleeding is common. The clinical presentation of CAA-related hemorrhage varies with the lesion’s size and location. Large lobar hemorrhages, particularly those extending towards the ventricles, can cause hemiplegia and depressed consciousness; in comparison, smaller lobar hemorrhages can cause more limited focal deficits, seizure, or headache. Although they are not specific to CAA, small subclinical leaks of blood called cerebral microhemorrhages (also known as microbleeds) are a relatively common neuroimaging finding in CAA.

Transient neurologic symptoms are a less common but

important manifestation of CAA. Patients complain of recurrent, brief (lasting minutes), often stereotyped spells of weakness, numbness, paresthesias, or other cortical symptoms that can spread smoothly over contiguous body parts. They may reflect abnormal activity (either focal seizure or spreading depression) of the surrounding cortex in response to the small hemorrhages.

CAA-related inflammation represents a distinct subset of CAA that present with acute or subacute cognitive decline rather than hemorrhage. Seizures, headache, and focal neurologic signs are common. There appears to be a spectrum of CAA-related autoimmune reaction ranging from perivascular inflammation to a true vasculitis with inflammation within and around the vessel wall, with a corresponding range in clinical severity of its manifestations.

Cognitive impairment is associated with advanced CAA. Studies have estimated that over 40 percent of patients with CAA-related ICH suffer cognitive decline during their life. Although the precise mechanism is unknown, many reports point to a vascular mechanism. Studies have correlated the number and presence of microbleeds with cognitive impairment and dementia, raising the possibility that these lesions are contributors to neurologic dysfunction, as well as markers of small vessel disease. Infarction is indeed another potential mechanism for CAA-related cognitive dysfunction. Some patients with extensive CAA present with progressive dementia along with ischemic white matter damage similar to patients with hypertensive vasculopathy and subcortical vascular dementia.

**CONCLUSIONS:** In patients presenting with cognitive impairment, transient neurological disorders, or acute or subacute cognitive decline, CAA should also be considered as a possible cause, especially in older patients and by multiple lobar hemorrhages on neuroimaging.

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### ADVOCACY AND POLICY ISSUES IN GERIATRIC MENTAL HEALTH

Dr. Karen Reimers, MD, FRCPC

IPA Bulletin Assistant Editor, *Around the World*

#### Key highlights:

- Because of the dramatic projected growth of the older population the number of people involved with geriatric forensic evaluations and policy issues is expected to increase: older people will constitute a greater proportion of patients, but also crime victims, offenders, judges, attorneys, witnesses, jurors, prisoners (not to mention geriatric psychiatrists).
- Future policy changes at the interface of geriatric psychiatry and the law can have a positive impact on our profession, but most importantly, progress on policy will benefit geriatric patients and their families.

Around the world, older people interact with all levels of the political, legal and judicial system. The American Association for Geriatric Psychiatry (AAGP) 2019 conference, to take place March in Atlanta, Georgia from 1-4 March 2019, has as its theme "Engage for Change: Preparing and Partnering for the Future of Geriatric Mental Health." This conference will highlight the importance of advocacy and partnerships to help ensure older adults have access to high quality care for mental health and substance use disorders. (1)

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but also crime victims, offenders, judges, attorneys, witnesses, jurors, prisoners (not to mention geriatric psychiatrists). (2)

There are many reasons why elders might be involved with the courts. Older people may find themselves involved with the law for a variety of reasons: as victims of abuse or exploitation, as fact witnesses in litigation, and as individuals fighting for their rights, either independently or with legal representation. (3, 4)

#### POLICY ISSUES AT THE INTERFACE OF LAW AND GERIATRIC PSYCHIATRY

##### Dementia and Decision-making Capacity

In some cases, capacity is not obvious, yet courts are

ADVOCACY AND POLICY ISSUES IN GERIATRIC MENTAL HEALTH, *continued on next page*



generally tasked with making a dichotomous or binary decision about the specific capacity question. (5)

### **Driving capacity**

Policy issues in this area concern the roles of physicians and other medical professionals in assessment and reporting, development of screening and testing requirements, schedules throughout the aging continuum, and funding for alternative means of transportation for elders who are no longer driving.

### **Testamentary and financial capacity**

Policy questions in financial capacity include protection of older consumers with cognitive impairment who make poor financial choices or financial mistakes including changes to their will. Strategies to foster this including disclosure, nudges, financial “driver’s licenses,” advance directives, fiduciaries, asset safe harbors, and increased regulatory oversight. (6) Some jurisdictions have extended “slayer” rules - developed to prevent killers from inheriting from their victims - to elder abuse, disqualifying persons from inheriting if they have been involved in abuse or financial exploitation of the deceased. (7)

### **Professional occupations, fitness for duty**

Policy issues in this area include reporting and mandatory screening requirements, the legal basis for mandated screening, fitness for duty evaluations of the aging professional, informed consent, and confidentiality.

### **Nursing home issues**

Policy issues in this area include reform of nursing facility regulation, mandated assessment and treatment requirements, insurance and payment reform, access to care issues, informed consent, patient rights including sexual decision making, and liability for negligence or injuries.

### **Guardianship reform**

Policy issues in this area include: developing standards of practice for guardians, addressing multi-state guardianship jurisdiction issues, promoting efficient guardianship monitoring, mediation for high-conflict cases.

### **Needs of older prisoners**

Policy and advocacy efforts in this area focus on economic concerns, the health and safety of older prisoners including specialized geriatric treatment and inmate housing, compassionate early release programs, and fostering the training of forensic psychiatrists with knowledge and expertise in aging-associated problems, especially neurocognitive disorders.

### **End of life issues, physician-assisted suicide**

Policy issues in the area of physician assisted suicide include: advocacy efforts both in opposition and support, legal assistance and education about assisted suicide where currently legal, efforts to legalize assisted suicide where currently illegal, advocacy for improved access to palliative treatment and hospice care.

## **CONCLUSION**

Despite the stigma associated with aging and dementia, most people are legally capable and do not automatically lack ability to make their own decisions. We are now facing a severe shortage of specialists with expertise to address the myriad issues at the interface of law and psychiatry.

Until recently, relatively little attention has been paid to the growing need for geriatric forensic evaluations and policy concerns at the interface of law and geriatric psychiatry. However, the field is rapidly developing and helpful new resources are rapidly appearing to assist geriatric forensic evaluators in addressing the myriad questions encountered in clinical practice and forensic settings. (8, 9)

Advocacy efforts are underway to better care for vulnerable older adults, and there is much future work to do in this area. Future policy changes at the interface of geriatric psychiatry and the law can have a positive impact on our profession, but most importantly, progress on policy will benefit geriatric patients and their families.

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### HEALTH INEQUALITIES – WHAT ARE THEY AND HOW CAN WE TACKLE THEM?

Dr Clarissa Giebel, PhD

University of Liverpool, NIHR CLAHRC NWC

#### Key highlights:

- People from low socio-economic backgrounds often struggle accessing the right healthcare at the right time
- Social and economic factors predicting healthcare access and use include gender, ethnicity, income level, housing, employment, and education
- Health inequalities can affect all types of healthcare, including dementia care and medication

Health inequalities are often neglected in service designs and research. To refer to the World Health Organization, 'health inequalities are avoidable inequalities in health between groups of people within countries and between countries.' Socio-economic factors, such as poor education, unemployment, poor housing, level of income, ethnicity, and gender, influence a person's health and their access to, and use of, healthcare services (i.e., Ellis et al., 2017).

In a recent analysis of large Household Health Survey in the North West of England (one of the most deprived regions in England), we found that unemployed people living in poor housing were more likely to attend an emergency department (Giebel et al., 2019). The survey asked residents aged 18 and over from over 20 disadvantaged neighborhoods. But it wasn't only socio-economic predictors that influenced healthcare utilization. People struggling with self-care abilities (e.g., washing and dressing, which are daily activities and particularly affected in dementia patients (Giebel et al., 2015)) were also more likely to attend an emergency department or a general practitioner.

That begs the question of whether older adults from poorer backgrounds might need different levels of healthcare, or if they struggle accessing the types of services they need in the first place. That does not have to be restricted to emergency departments and doctors. This could include outpatient services, or even medication. Cooper and colleagues (2016) actually looked into medication prescription for people with dementia in the UK, and they found that people with dementia from more advantaged backgrounds were 25%

more likely to be prescribed anti-dementia medication than those from the most disadvantaged backgrounds. Also, looking at ethnicity, a social factor that can influence health inequalities, people from South Asian minority groups are less likely to recognize dementia (Giebel et al., 2016). As a result, they are less likely to see a doctor about their symptoms. This clearly shows how health inequalities are not only present in accessing an actual service location (such as a doctor's office for surgery), but also other healthcare services people might need.

Whilst more and more is being done to pinpoint exactly where health inequalities are experienced, fewer initiatives are put into practice and implemented in order to tackle health inequalities. Of course, it is difficult. It requires taking into consideration a lot of social and economic factors. So how can this be done? One tool that can be used to guide this process and help reduce health inequalities is the *Health Inequalities Assessment Tool* (<http://www.hiat.org.uk/>). It's an easily accessible online form designed with members of the public, and is increasingly being used in the development of research and implementation. On a logistical level, one important factor or ingredient is to have a supportive healthcare organization on board, and maybe even has identified the need themselves. Clinicians need to be provided with the right research tools and academic support if necessary to help them implement changes in a structured way, and then to evaluate afterwards whether these practice changes have helped reduce health inequalities. For example, if older adults struggle getting to their appointment for

HEALTH INEQUALITIES – WHAT ARE THEY AND HOW CAN WE TACKLE THEM?, *continued on next page*

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socio-economic reasons, such as not having enough money for a taxi or public transport, then perhaps an outpatient service should come and visit the patients in their own home. This way, patients would get equal access to the care they need, regardless of their background.

Often, organizations might not be aware their patients struggle to access appointments because of their different backgrounds. So, maybe one step to take is raising awareness that some patients want to see their healthcare professional, or are in need of medication, but struggle to attend in the first place. These people and patients need to be enabled in the best way possible to get the care they need. The World Health Organization has a great deal of information on how health inequalities may be tackled further on a global scale ([https://www.who.int/social\\_determinants/en/](https://www.who.int/social_determinants/en/)). We may think that poor health access is only present in third world countries, but actually, it can often be found right on our door step.

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Dr. Giebel is a dementia researcher specializing in everyday functioning and enabling people with dementia to stay in their own home for as long as possible. In her current role at the University of Liverpool and at the NIHR CLAHRC NWC, she particularly focuses on health inequalities in people with dementia and their carers, working on both national and international projects.

## COURSE OF CARE AND MULTIDISCIPLINARY INTERVENTION IN PATIENTS WITH DEMENTIA

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### Key highlights:

- Understanding psychopathology in the context of dementia will improve patient care
- Imaging biomarkers may be the future of neurodegenerative disease diagnosis.
- Multidisciplinary collaboration and greater human resources will accelerate the identification of solutions to the current problems with dementia care

The Spanish Psychogeriatric Society has started a training program in this area that will be held throughout different cities in Spain. Its primary goal is to disseminate

Psychogeriatrics as a branch within Psychiatry. Its secondary goal is to train professionals to care for older adult with dementia and psychiatric disorders. So far two courses have

COURSE OF CARE AND MULTIDISCIPLINARY INTERVENTION IN PATIENTS WITH DEMENTIA, *continued on next page*

been held on dementia care with similar approaches. The first one was held in Valladolid at the end of June and this second course was held in Vigo 8-9 November 2018.

As a member of the Board of Directors of the Spanish Psychogeriatric Society (SEPG), I was in charge of coordinating this course, which was titled II Course of Care in Multidisciplinary Intervention in Patients with Dementia. For this, we also had the collaboration of the Galician Network of Research in Dementia (REGIDEM), the Alzheimer Galicia Federation (FAGAL) and the Barrié Foundation Vigo, which provided facilities for this event and is one of the most surprising art centers in Vigo.

More than 100 professionals from several medical specialties and other psychogeriatric related professions applied to this training course, specialists in Neurology, Psychiatry, Psychology and Geriatrics, physicians and psychologists in training, primary care physicians, other professionals working in nursing homes, forensic pathologists, and nurses.

The course began with the extraordinary presentation of Dolores Franco, who spoke about the psychological and behavioral symptoms in dementia and psychopathology as a clinical tool, it is how psychiatry, and specifically psychopathology describe a variety of psychiatric symptoms linked to dementia and how this is very useful in the diagnostic process and treatment. As a tool, we use the metaphor of psychiatric disorders to be able to treat these syndromes that appear linked to cognitive impairment, so we will treat a manic syndrome, such as mania, as an etiology of dementia, and not a primary psychiatric disorder. It is very useful to know the psychopathology of mental disorders in order to identify these conditions in dementia.

Another paper was dedicated to neuropsychology as a diagnostic test, highlighting the criteria for requesting this neuropsychological examination. Marta Torrente, in a clear and succinct way, described the different clinical contexts in which this discipline can shed light on the diagnostic process. With the same objective, J.R. Lorenzo explained the usefulness of neuroimaging in the diagnosis of dementia. In his opinion, it should be a second-order

diagnostic test in the study of dementia, and keeping the clinical and neuropsychological assessment in the first place. Neuroimaging can give us information about the etiology of dementia, that is, greater diagnostic specificity. Therefore, structural neuroimaging with either a non-contrast CT or MR scan in the routine initial evaluation of patients with dementia is appropriate. The future is the role of neuroimaging as a biomarker for neurodegenerative diseases and PET/MR imaging as a new frontier in Alzheimer's disease and other dementias (1).

Regarding the treatment of dementia, the presentations were divided into three sections, specific treatment of the cognitive symptoms of dementia and the non-pharmacological and pharmacological treatment of the psychological and behavioral symptoms of dementia. D. Pérez updated us on drugs for the treatment of Alzheimer's disease and other dementias and new drugs under clinical trials in 2018. Of 26 agents in phase III, 31% are directed to palliate psychiatric symptoms, 4% are symptomatic cognitive enhancers, and 65% are disease modifying therapies (2). M. Sánchez explained different non-pharmacological strategies in the management of agitation and aggression associated with Alzheimer's disease (3) as well as other interventions such as aromatherapy, music therapy, light therapy or sensory stimulation, such as Snoezelen therapy (4). The pharmacological treatment of SPCD was addressed by J. Olivera. According to this presentation it is worth mentioning the contribution of the SEPG for the use of antipsychotics in the elderly (5)

Promoting multidisciplinary research was a major goal, for this reason we wanted to have the point of view of primary care physicians in the approach to dementia. Primary care is the first point of contact in the healthcare system, acting as the 'front door' of the health system. This first screening is very important to get the optimal diagnosis and treatment of dementia. M. Dominguez made a special effort to convey the difficulties they deal with in their daily work and proposed possible solutions to speed up this work (6), such as starting a treatment with memantine from primary care once the patient is already taking an acetylcholinesterase inhibitor.

The neurological research on dementia is vitally important for the progress of care given that diagnosis is achieved very late. We know that 30-40% of cognitively healthy older people already have neuropathological changes. M.J. Moreno made an enormous effort to summarize new advances in the biological diagnostic criteria for their classification in this training course (7).

We did not want to forget dementia care during terminal stage dementia, so we invited Jorge Pla and Irene Esperón. They expressed the need for palliative care, both inpatient and outpatient care, from the psychiatric and psychological point of view, respectively.

Finally, we closed this course with a debate table entitled “Where do we locate dementia?”, chaired by the head of the Psychiatry Department of Vigo, J.M. Olivares, and with very different interventions from different disciplines. We deliberated solutions to the current problems in our healthcare system to help people with dementia, which basically focused on the need for greater human resources and multidisciplinary collaboration.

### For further reading:

1. *PET/MR Imaging: new frontier in Alzheimer’s disease and other dementias.* Xin Y. Zhang, Zhen L. Yang, Guang M. Lu, Gui F. Yang and Long J. Zhang. *Front. Mol. Neurosci.*, November 2017, vol 10, art 343
2. *Alzheimer’s disease drug development pipeline: 2018.* Jeffrey Cummings, Garam Lee, Aaron Ritter, Kate Zhong. *Alzheimers Dement (N Y)*. 2018; 4: 195–214.

3. *Management of agitation and aggression associated with Alzheimer disease.* Ballard, C. G. et al. *Nat. Rev. Neurol.* 5, 245–255 (2009)
4. *Multisensory stimulation for people with dementia: a review of the literature.* Sánchez A, et al. *Am J Alzheimers Dis Other Demen.* 2013;28(1): 7-14
5. *Documento de la Sociedad Española de Psicogeriatría sobre el uso de antipsicóticos en personas de edad avanzada.* [www.viguera.com/sepg](http://www.viguera.com/sepg). *Psicogeriatría* 2017; 7 (Supl 1): S1-S37
6. *Dementia: assessment, management and support: summary of updated NICE guidance.* J Pink et al. *BMJ* 2018;361:k2438
7. *NIA-AA. Research framework: Toward a biological definition of Alzheimer’s disease.* *Alzheimer’s & dementia* 14 (2018): 535-562
8. *Raimundo Mateos, Manuel Franco and Manuel Sánchez (2010). Care for dementia in Spain: the need for a nationwide strategy.* *Int. J. Geriat. Psychiatry*, 25: 881-884. doi:10.1002/gps.2591



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### HONG KONG PSYCHOGERIATRIC ASSOCIATION 2018 ANNUAL SCIENTIFIC MEETING CUM TRIPARTITE PSYCHOGERIATRIC MEETING

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The Hong Kong Psychogeriatric Association's (HKPGA) 2018 Annual Scientific Meeting was held at Hyatt Regency Hong Kong on 24 November 2018. Geriatric psychiatrists, geriatricians, and healthcare professionals from Hong Kong, Taiwan, and Mainland China, participated in the meeting with enthusiasm. The President of HKPGA, Professor Helen Chiu, President of the Taiwanese Society of Geriatric Psychiatry, Dr. Tzung-Jeng Hwang, and Immediate Past President of the Chinese Society of Psychiatry, Professor Yu Xin presented opening remarks for this conference.

Professor Edmond Chiu, Professor Emeritus of the Academic Unit for Psychiatry of Old Age of the University of Melbourne, was the keynote speaker and gave a presentation titled *"The Underpinnings of Old Age Psychiatry - Through a Three Decades Retroscope"*. He described the biopsychosocial paradigm first proposed by George Engel in 1977. Professor Chiu pointed out the neglect of physical health as an overcorrection for this paradigm. He also described the social needs of older persons, potentially modifiable risk factors for cognitive health, and spoke of long ignored spiritual/religious dimension. Finally, Professor Chiu proposed an updated

paradigm: the biopsychosocial, cognitive, and spiritual approach, and believes it is now more appropriate for old age psychiatry.

Following the 20th anniversary celebration of the Hong Kong Psychogeriatric Association was the Expert Forum on Elder Abuse. Ms. Stephanie Wong, a Social Work Consultant from the Hong Kong Family Welfare Society, presented on *"Abuse of Elderly with Dementia: Risk Factors, Management and Caregivers Support"*. She described risk of abuse for elderly with dementia, including behavioral disturbance, functional impairment, sociodemographic characteristics, health-



HONG KONG PSYCHOGERIATRIC ASSOCIATION 2018 ANNUAL SCIENTIFIC MEETING CUM TRIPARTITE PSYCHOGERIATRIC MEETING, *continued on next page*

related factors in the caregiver, interpersonal relationships, and environmental risk factors. Dr. Carolyn Kng, Geriatrician Service Director (Primary & Community Health Care) of Hong Kong East Cluster, gave a case sharing on elderly abuse from a geriatrician's perspective. She shared her encounters with abused elderly people and their families and showed dynamics of elder abuse management.

The Tripartite Psychogeriatric Meeting took place in the afternoon on the same day. First, Professor Helen Chiu presented on fluctuating mental capacity. She suggested that capacity can fluctuate. Capacity is not merely decision-specific and time-specific, but is situation specific. She elaborated on the fluctuation between good days and bad days in Alzheimer's dementia, vascular dementia, and dementia of Lewy bodies. Secondly, Professor Hua-Li Wang, Psychiatrist from Peking University Sixth Hospital, introduced

preliminary findings on the effect of depression on mild cognitive impairment in Mainland China. Lastly, Dr. Yung-Jen Yang, Psychiatrist of Tsaotun Psychiatric Center, presented on road safety and psychogeriatrics with recent updates and developments in Taiwan. He described an algorithm for senile driver's license renewal in Taiwan introduced in July 2017 followed by the influence of stopping those with dementia from driving. Dr. Yang also identified the aid to help elderly people make the decision stop driving.

There was also a brief retirement ceremony for Professor Helen Chiu and Dr. Chan Wah Fat (one of the past presidents of HGPGA), honoring their contributions to geriatric psychiatry. Overall this one-day meeting was a success. All participants interacted and exchanged experiences actively. The next tripartite meeting is planned to be held in Tianjin, China.

## VIRTUAL REALITY, AUGMENTED REALITY AND MIXED REALITY IN GERIATRIC MENTAL HEALTH CARE

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### Key highlights:

- Lightweight, high-resolution screens have created a boom in the development of reality-related technologies.
- Virtual, augmented and mixed reality may have potential clinical use in geriatric mental health in the future.

A number of reality-related technologies have been developing over the past three decades and have begun to boom in the most recent decade as smartphone technologies have matured. With the advent of the lightweight, high-resolution screens, reality-related technologies have become a hotspot for new technological development. Recently, many big companies have launched and commercialized their products, and as such this technology column will introduce and discuss possible applications of these technologies in the scope of geriatric psychiatry.

There have been a variety confusing terms about reality technology, even the term itself. Currently, the most common

terms are virtual reality, augmented reality, and mixed reality which refers to the experience of actuality, while simulated reality is refers to a distinct entity or concept that will not be discussed here. First, virtual reality (VR), augmented reality (AR) and mixed reality (MR) must be defined.

These three terms are not fully recognized in major dictionaries, although they are quite common in our daily conversations. Both VR and AR, but not MR, have been explained in both the Oxford and Cambridge Dictionaries (the online version). Here are quotations from Oxford Dictionary about VR and AR.



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VIRTUAL REALITY, AUGMENTED REALITY AND MIXED REALITY IN GERIATRIC MENTAL HEALTH CARE, *continued from page 24*

*“Virtual reality: The computer-generated simulation of a three-dimensional image or environment that can be interacted with in a seemingly real or physical way by a person using special electronic equipment, such as a helmet with a screen inside or gloves fitted with sensors.”, and, “Augmented reality: A technology that superimposes a computer-generated image on a user’s view of the real world, thus providing a composite view.”*

However, there have been various definitions and elaborations on these reality-related technologies in other fields of discipline (see appendix for examples).

Because dementia is not well understood by the general public, many organizations, charities, and academic societies have been advocating for an improved understanding of dementia. However, most people simply have literal or intellectual knowledge about dementia. Educational literature has proved that vicarious experiences are one of the most efficient ways to gain understanding and develop empathy, especially in the field of mental health. Since 2016, throughout the UK, Alzheimer’s Research UK (ARUK) has been developing a project entitled “A Walk through Dementia”, in which virtual reality technology has been implemented as a practical tool to aid the understanding of dementia. Detailed information can be found at the official website (<http://www.awalkthroughdementia.org>). With commercial VR devices, a cardboard headset (see Figures 1 & 2) available from ARUK, or even simply watching on mobile phones or tablets, users can download the App software and programs, and experience life in a way that more closely reflects the life of dementia patients. It is highly recommended that caregivers for dementia patients use VR to have this experience.

VR, AR and MR may have potential clinical use in geriatric mental health in the future. The following websites and articles in this column share more information about the ongoing development and applications of these technologies and feedback is sincerely welcomed.

### Appendix:

The exemplified websites addressing the explanations of AR, VR and MR.



- A. <https://www.forbes.com/sites/quora/2018/02/02/the-difference-between-virtual-reality-augmented-reality-and-mixed-reality/#7387a63c2d07>
- B. <https://www.realitytechnologies.com>
- C. <https://rubygarage.org/blog/difference-between-ar-vr-mr>



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