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## PRESIDENT'S MESSAGE – MARY SANO

Dear Colleagues

As a neuropsychologist, who has spent most of my life working in dementia and cognitive impairment in the elderly, I am pleased that there is growing attention to this topic. This is tempered by the fact that these past few months have seen several reports of negative results on some of the most high profile approaches to treating Alzheimer's disease (AD). Specifically, in March, Biogen and Eisai announced they would terminate all currently ongoing aducanumab trials, because an interim analysis indicated "futility" for the two major ongoing trials, EMERGE and ENGAGE. That is these studies would not find a beneficial effect of their primary endpoint. This failure has been a blow to much of the drug development field because this agent very effectively removed amyloid from the brains of patients with AD and it was hoped that a clinical benefit would result. Several other molecules that were in clinical trials and modify different aspects of amyloid accumulation in the brain have also failed, and some may even worsen cognitive function. While there are other targets and there is enthusiasm for starting earlier to prevent cognitive loss in those with amyloid, there is some skepticism and even concern about these highly technical and very costly approaches to preventing dementia.

Perhaps that is why I have been so fascinated by the interest in dementia prevention. The recent release of the WHO Guidelines on Risk Reduction of Cognitive Decline and Dementia is one example of a systematic look at approaches to reducing risk. The challenge of writing guidelines for global communities is great, and while the task of summarizing evidence is huge, one is also struck by the lack of information for a breadth of populations. For example, is the recommendation for someone at 60 years of age the same as for someone at 80; Do recommendations get tailored to your past health history; Does region and climate change the benefit of an intervention? Does physical activity have a benefit in a place where air quality is low or climate is tropical? This complexity was realized in the WHO report which resulted in only two "strong" recommendations for reducing cognitive decline among the twelve areas described in the Executive Summary. Of note, these two areas had only low (tobacco cessation) or moderate (physical activity)



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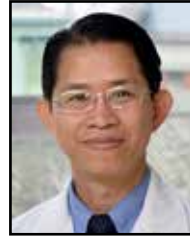
quality of evidence. In the case of tobacco cessation, the recommendation is further modified by adding it may have other health benefits. Among dietary interventions, the Mediterranean-like diet was only conditionally recommended. An unusual occurrence was the “strong recommendation” to “Not recommend” specific supplements (vitamin B and E) polyunsaturated fatty acids and complex supplements. This maybe a bit confusing and it will be important to observe the impact and uptake of this recommendation.

Reduction of several other risks that were evaluated and received “conditional” status or no recommendation for reducing and risk of cognitive decline and dementia. For example, social activity interventions, management of depression, and management of hearing loss, receive no recommendations for reducing cognitive decline and dementia. In many cases this is due to limited data, and in some cases (hearing loss, and management of depression) previously published guidelines exist to recommend the intervention for other health reasons. This report reminded me that we can never forget the whole person, especially in old age. While some specific interventions may not currently have evidence to support a direct effect on cognition, they may be relevant to a wider range of issues that address “Better Mental Health for Older Persons”.

Finally, I want to share with you my observation that both strong and conditional recommendations require modifying behavior to improve health outcomes. Behavioral health has long been part of the mental health field. However, the specific and specialized field of behavioral health in aging is upon us. The next decades will see people living longer and we at IPA want to help collect the evidence base to tell them how to live better. Studies to learn the best methods to motivate aging populations are in desperate need. Using technology in age-friendly ways to improve compliance, to track progress on new habits and to receive support to persevere in healthy activities are all worthy of study. I hope this mission will mean as much to you as it does to me.

### EDITOR'S NOTE – TZUNG-JENG HWANG

IPA has been a leader in developing definitions and advancing understanding of neuropsychiatric symptoms in dementia. In 2019 March, IPA launched an expert consensus meeting in defining psychosis in dementia in Lisbon, Portugal during the AD/PD meeting period. In this issue, there is a brief report on this initiative. The 2019 IPA Congress in Santiago de Compostela, Spain, is now in good shape, with eight pre-Congress



workshops, at least six plenary sessions, 20 symposiums, and more than 200 free communications and posters. We can expect a fruitful scientific conference with spiritual nourishment. Furthermore, in order to increase our membership and global impact, President Dr. Sano led the Board of Directors to work on a plan to increase the board size, so that we can have more leaders and colleagues around the world working together to make the world a better place for the elderly.

I am pleased that, in this issue, there are seven articles, four in **“Research and Practice,”** and three in **“Around the World.”**

In **“Research and Practice”**: Dr. Lam (Canada) introduces an interesting and important study: SPRINT-MIND, a randomized controlled trial of intensive systolic blood pressure control to a target of under 120 mmHg. It is the first major trial to demonstrate that an intervention reduces the incidence of mild cognitive impairment. Dr. Huang (Taiwan) updates us on the issue of how suicide prediction models work. The conclusion is application of suicide risk stratification is not recommended considering the poor predictive validity, insufficient corresponding evidence-based treatment, and possible negative clinical impact. Dr. Sion (Netherlands) discusses how an experienced quality of care is a process of expectations before, during, and after an assessment in the context of receiving care. Finally, Dr. Valzolgher (Italy) portrays a patient with dementia of Lewy body whose visual hallucinations were successfully treated with memantine.

In **“Around the World”**: Dr. Giebel (UK) shares with us her precious experiences in how she and a clinician have benefited from working on service evaluation together, sharing knowledge and learning from being immersed in the other setting (academia and clinical practice). Dr. Liang (Taiwan) recommends a good book *The Mental Health and Illness of the Elderly*, edited by our IPA colleagues, Helen Chiu (Hong Kong) and Ken Shulman (Canada). This book is divided into three sections: The Global Challenge of Aging Populations; Diagnosis and Assessment; and Treatment and Services. Finally, Dr. Reimers (USA) reports on the 2019 AAGP Annual Meeting in Atlanta, Georgia. The meeting was a resounding success covering a range of topics, many related to policy and advocacy in geriatric psychiatry.

I cordially invite IPA members to submit articles to share thoughts and experiences with us! You can reach us at [IPABulletin@ipa-online.org](mailto:IPABulletin@ipa-online.org).

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# Save the Date

## IPA/SEPG Joint International Congress

 31 AUGUST - 3 SEPTEMBER 2019 

*Santiago de Compostela, Spain*



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Better Mental Health for Older People



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[www.ipa-online.org/2019congress](http://www.ipa-online.org/2019congress)



# Pre-Congress Workshops

31 AUGUST 2019

### FULL DAY WORKSHOPS:

Primary Care Mental Health in Older People  
The 6th International Capacity Conference

### HALF DAY WORKSHOPS:

Improving Caregiver Interventions: New Clinical Approaches and Research Strategies  
Updates/ Controversies in Alzheimer's Disease: Risk Factors, Protective Factors and  
Treatments

Measurement of Challenging behavior (CB); views from different perspectives  
International initiatives to address inappropriate psychotropic use in long term aged care  
PAIN in Older Adults with Cognitive Impairment especially Dementia

### IPA ANNOUNCES LOSS OF FOUNDING PRESIDENT MANFRED BERGENER (1936-2019)

Dr. Professor Manfred Bergener, Inspirationalist, visionary and first President of the International Psychogeriatric Association (1982-1987), died in March 2019, in Koln, Germany.

Dr. Prof. Bergener agreed to assume leadership of this fledgling organization at a Congress in Cairo, Egypt in November 1982. At that time, several prominent leaders in the small field of geriatric mental health did not believe that the time was right to form an international organization. Moreover, there had been a recent flareup between Israel and the neighboring countries which reached its zenith at the time of the Congress.

Nevertheless, despite these tensions and the fact that IPA had no funds, no paid membership and lacked an organizational structure, Dr. Bergener's vision, energy, and commitment allowed IPA to survive and thrive.

He espoused three basic principles:

1. IPA would address the "nation of older people." Whether in Toronto, Teheran, Tel Aviv or Timbuktu, older people experienced dementing illnesses, depression, psychosis, adjustment disorders, or serve as a models of successful aging. Therefore, IPA would not allow geographic, political or religious differences to interfere with our focus on the "aging nation."
2. Our emphasis would be "holistic" ("biopsychosocial"). We would focus on all elements from basic science through clinical care to systems of service delivery, incorporating training models and the latest research in all areas.
3. IPA would not limit itself to only one illness. Our focus would be broad, and we would stress the interrelationship between illnesses, such as depression in dementia, or psychological reactions to medical co-morbidity.

Under Dr. Bergener's leadership, IPA established a Newsletter in 1983. As Medical Director of Rheinische Landesklinik in Cologne, he organized the first IPA Regional meeting in 1984.



Under his leadership and direction, over the next five years IPA held Congresses in Umea, Sweden; Chicago, USA; and Tokyo, Japan. We also brought regional workshops to Paris, France; Vienna, Austria; Budapest, Hungary; and Toronto, Canada. Through Dr. Bergener's initiative, he consummated an agreement with Springer to publish an IPA Journal, *International Psychogeriatrics*, and appointed Gene Cohen as the initial editor. This successful Journal has achieved high success and continues into its fourth decade.

In 1989, Dr. Bergener arranged for Bayer to support a Research Award. Several young recipients have evolved into major leadership roles in their fields and in their countries. Following his retirement from the Board of Directors, Dr. Bergener organized the highly successful Congress in Berlin in 1993.

He was also a man of the arts - an accomplished drawer/sketcher, and an art collector, as well as a man with an extensive knowledge of a wide range of music.

Without Dr. Bergener, it is unlikely that IPA would have survived for very long. He brought a European presence, an understanding of the need for communication among the leaders in the field to understand their common problems from different perspectives and experiences, his scientific and clinical perspectives, and the vision of what was needed to position an organization to grow into a future and address the growing need of mental health in the elderly.

Through his early efforts and the development of an intact infrastructure, IPA lives today at 37 years old.

Manfred Bergener is survived by his wife, Uta, three daughters - Silke, Henrike and Anja, and three granddaughters - Paula, Julia and Sophia.

image credit: <http://www.prof-manfred-bergener.de/>

### A REPORT ON PSYCHOSIS IN COGNITIVE IMPAIRMENT INITIATIVE OF THE IPA

*Tzung-Jeng Hwang, MD, PhD*

*Department of Psychiatry, National Taiwan University Hospital, Taiwan*

IPA has been a leader in defining neuropsychiatric symptoms in dementia. Taking the opportunity of the 2019 AD/PD meeting in Lisbon, Portugal, IPA convened a group of experts to re-examine the definition of psychosis in dementia on 31 March 2019. The purpose was to provide updated criteria for clinical use and research application. Beginning at 8 AM, the IPA President Dr. Mary Sano made the opening remarks and provided the goal of this meeting. Dr. George Grossberg then reviewed the terminology and history of IPA's past engagement in this field. Dr. Jeff Cummings presented the process for definition development and potential application in clinical trials and research. After that, Dr. Dilip Jeste reviewed the current criteria (which he and Dr. Finkle created 20 years ago), their strengths and weaknesses, and opportunities for improvement. This was followed by a presentation of the survey results by Dr. Sano. The pre-meeting survey conveyed many thoughts on how to further improve the current criteria.

The afternoon session started with Dr. Debby Tsuang's talk on dementia with Lewy body and other dementia-related psychosis. Dr. Debby Gerritsen then discussed commonly used psychosis rating scales and how they would influence definition development. Dr. Raymond Koopmans described the impact of psychosis on caregivers, costs, and health outcomes. There was then a discussion on regulatory aspects of a definition of psychosis. Finally, Dr. Cummings, the discussion leader, led the group discussion on how to bring the project to fruition. The consensus meeting was adjourned at 4:30 pm. Throughout the day, all the participants actively exchanged their thoughts and ideas, and reached a preliminary consensus. Further work will be continued in the future. Overall this was a wonderful and successful meeting.



## IPA SOCIAL AT AAIC 2019

Will you be in Los Angeles, USA for AAIC this July?

Are you interested in learning more about IPA, meeting other IPA members and hearing the latest programming updates?

Mark your calendars for Wednesday, 17 July - this will be one event you won't want to miss!

6:30-8:30 pm

17 July 2018

Tom's Urban at LA Live

1011 S Figueroa St

Los Angeles, CA United States

This complementary reception is open to IPA members and invited guests and will include light appetizers and drinks along with a brief welcome from IPA leaders.

Featuring an urban vibe and a unique approach to cuisine, Tom's Urban is an adventure in spirits, food, and entertainment. Conveniently located next to the LA Convention Center in the the sports and entertainment district known as LA LIVE, Tom's Urban is an easy walk from any of the AAIC 2019 host hotels. [Sign up](#) is required to permit accurate space availability.



## UPCOMING IPA MEETINGS

### IPA Social Event at AAIC 2018

17 July 2019

[IPA Social Event at Tom's Urban](#)

6:30-8:30 pm

Los Angeles, CA, USA

### IPA/ SEPG Joint International Congress

31 August -1 September 201

[Joint International Congress](#)

Santiago de Compostela, Spain

## AFFILIATE MEETINGS

### Canadian Academy of Geriatric Psychiatry (CAGP) 28th Annual Meeting

25-26 October 2018

Banff, Alberta, Canada

<http://cagp.ca/>

### Royal College of Psychiatrists in Scotland Old Age Faculty Autumn Meeting 2019

22 November 2019

Edinburgh, Scotland

<http://www.rcpsych.ac.uk/events/>



### SPRINT-MIND: THE BEST EVIDENCE TO DATE LINKING BLOOD PRESSURE AND COGNITIVE IMPAIRMENT

*Kenneth Lam, MD FRCPC ABIM certified in Internal Medicine  
Clinical Fellow, Division of Geriatrics, Department of Medicine, University of Toronto*

#### Key highlights:

- SPRINT-MIND is a randomized controlled trial of intensive systolic blood pressure control to a target of under 120 mmHg and is the first major trial to demonstrate that an intervention reduces the incidence of mild cognitive impairment.
- The quality of evidence is limited because statistical significance was met on a secondary outcome but not the primary outcome of probable dementia.
- The result is gaining broader acceptance because of mechanistic plausibility: mild cognitive impairment precedes dementia and the trial was terminated early for benefit in cardiovascular events, potentially limiting the ability to observe the development of dementia.
- It offers further support for the hypothesis that hypertension causes dementia, but may not be practice-changing as intensive blood pressure control is already in guidelines due to cardiovascular and mortality benefit.

Dementia has multiple well-documented, potentially modifiable risk factors such as hearing loss, depression, and hypertension. However prior to this trial, no randomized controlled trials existed demonstrating that mitigation of hypertension resulted in fewer cases of mild cognitive impairment or dementia. The Systolic Blood Pressure Intervention Trial – Memory and Cognition in Decreased Hypertension (SPRINT-MIND) published this January is the first to do so, offering encouraging, yet indefinite evidence that we can prevent or delay dementia<sup>1</sup>.

#### Methods

The SPRINT trial was a single-blind randomized controlled trial published in 2015 demonstrating that intensive systolic blood pressure management (target <120mmHg) versus standard management (target <140mmHg) reduced the risk of a composite outcome of myocardial infarction, stroke, heart failure and cardiovascular death (1.65% per year vs. 2.19% per year, HR 0.75, 95% CI 0.64-0.89)<sup>2</sup>. It enrolled 9,361 adults over the age of 50 (mean age 67.9 years) with a systolic blood pressure between 130 and 180 mmHg and increased cardiovascular risk. Excluded patients were those with dementia, on dementia-modifying medications, prior stroke,

diabetes mellitus, or residing in a nursing home, among other criteria.

SPRINT-MIND was a pre-planned sub-study of the SPRINT trial. To test the hypothesis that intensive blood pressure reduction in this cohort would reduce the primary outcome of probable all-cause dementia, they planned cognitive assessments alongside the main trial at baseline, every two years, and at study completion. Secondary outcomes were mild cognitive impairment (MCI) and a composite outcome of dementia or MCI.

Cognitive assessment at each follow-up consisted of a screening assessment (including tests of learning, memory, and processing speed), additional functional assessment if patients scored positive on the screening, and an extended neuropsychological battery if functional impairment was identified or if errors in delayed recall were noted. These data, along with information about the patient's mood and health were used by two members of an adjudication panel to independently determine one of three possible outcomes: no impairment, MCI (if there was a decline in cognition from the patient's baseline in at least one cognitive domain), or dementia (if there was cognitive decline and functional



impairment). Disagreements were discussed by the full panel and decided by majority vote. A diagnosis of MCI required an adjudication decision of at least MCI on two successive visits.

SPRINT was terminated before the pre-planned average of five years due to early signs of benefit in the primary outcome of reduced cardiovascular events, after which point blood pressure medications were no longer supplied by the trial and care was returned to primary care physicians. This prompted investigators to extend follow-up with one additional visit after study completion.

## Results

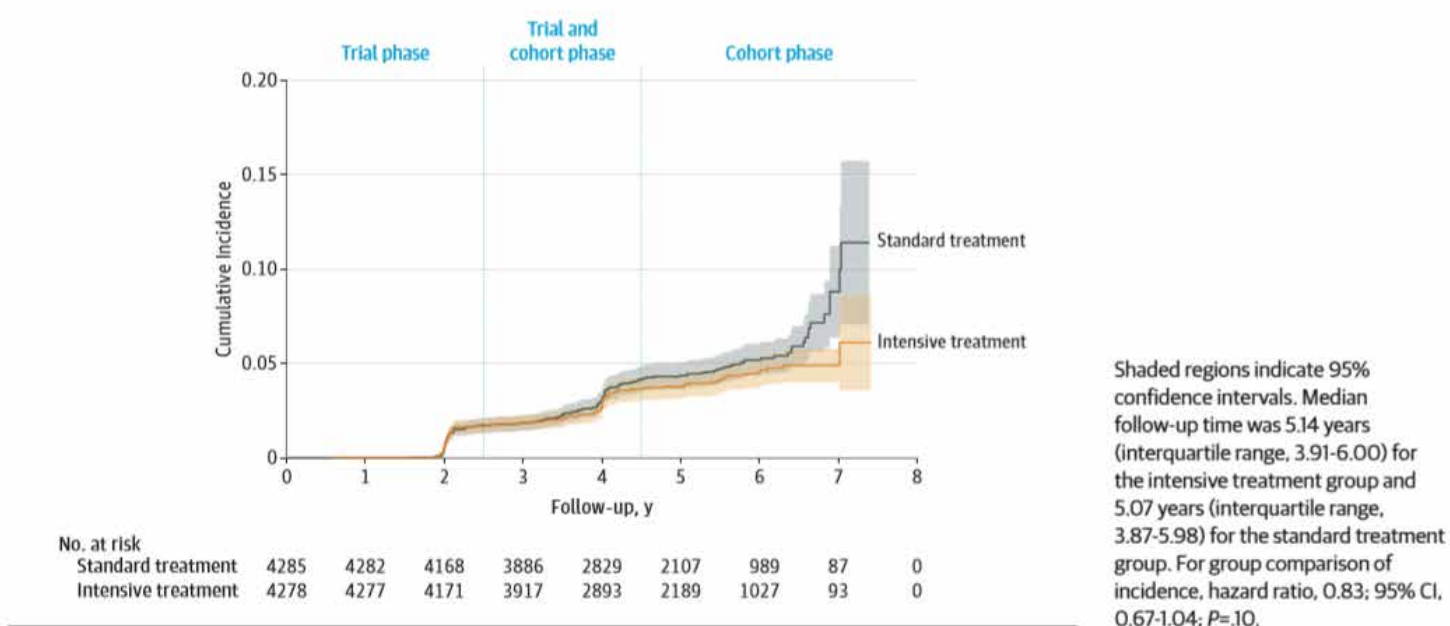
Although there was no statistically significant reduction in probable dementia (7.2 vs 8.6 cases per 1000 person-years, HR 0.83, 95% CI 0.67-1.04), the authors did find a statistically significant reduction in their secondary outcome of MCI (14.6 vs 18.3 cases per 1000 person-years, HR 0.81, 95% CI 0.69-0.95) and in the composite outcome of MCI or dementia (20.2 vs 24.1 cases per 1000 person-years, HR 0.85, 95% CI 0.74-0.97). The median intervention period was 3.34 years and median follow-up period was 5.11 years. During the intervention period, the mean between-group difference in

blood pressure was 13.3 mmHg, but at extended follow-up, the between-group difference fell to 6.4mmHg. Completion rates of cognitive assessment were also greater than 90% at pre-planned visits but fell to 60% during extended follow-up. Risks of treatment included hypotension (HR 1.67), syncope (HR 1.33), electrolyte abnormalities (HR 1.35) and acute kidney injury (HR 1.66).

## Cautions

Commentaries have highlighted that a lower-than-expected incidence of dementia and early termination of the trial contributed to the failure to demonstrate significance on the primary outcome<sup>3,4</sup>. Without a positive primary outcome, it is premature to definitively state that intensive blood pressure management prevents dementia, but results remain encouraging because of mechanistic plausibility and the absence of higher-quality evidence. It seems there was less MCI in the intervention group, and since MCI often precedes dementia, SPRINT-MIND may have simply followed patients for too short a time to observe the development of dementia<sup>5</sup>. Blood pressure control in the intervention group was also less intense once the trial was terminated, further

**Figure 2. Probable Dementia by Treatment Group**



SPRINT-MIND: THE BEST EVIDENCE TO DATE LINKING BLOOD PRESSURE AND COGNITIVE IMPAIRMENT, *continued from page 9*

attenuating the expected effect. As a result, the Alzheimer's Society has funded an extension of this trial (SPRINT-MIND 2.0) to continue exploring links between hypertension control and dementia prevention<sup>6</sup>.

The mean age of trial participants was 67.9 years, limiting the generalizability of results to older patients.

Other data from SPRINT-MIND are awaiting publication. In their protocol, 2,800 patients were planned to receive more comprehensive cognitive assessments at each follow-up visit. Published results from their neuropsychological batteries will help place the results of SPRINT-MIND in the context of other randomized controlled trials that have observed domain-specific improvements with other interventions such as cognitive training and multidomain interventions<sup>7,8</sup>. A smaller subset of 640 proposed patients received MRIs, and those results will help support the hypothesis that dementia from hypertension is mediated by small vessel ischemic disease.

### Implications

The study is major progress in our scientific understanding of dementia prevention, offering strong support that hypertension causes it and is something we can intervene upon. It is less clear if SPRINT-MIND will be practice-changing, as the cardiovascular and mortality benefits of intensive blood pressure control demonstrated by the parent study SPRINT is already making its way into guidelines<sup>9</sup>.

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1. The SPRINT MIND Investigators for the SPRINT Research Group, Williamson JD, Pajewski NM, et al. Effect of Intensive vs Standard Blood Pressure Control on Probable Dementia: A Randomized Clinical Trial. *JAMA*. 2019;321(6):553. doi:10.1001/jama.2018.21442
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Kenneth Lam is a Clinical Fellow in the Division of Geriatrics, Department of Medicine at the University of Toronto, as well as Research Trainee at the Women's College Research Institute. He will be starting a fellowship with the VA Quality Scholars Program in San Francisco in July 2019.

### RISK ASSESSMENT AND PREDICTION OF SUICIDE: TOWARD A NEEDS BASED APPROACH

Wei-Chia Huang<sup>1</sup>, Shu-Sen Chang<sup>2</sup>, Tzung-Jeng Hwang<sup>1</sup>

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#### Key highlights:

- Current suicide prediction models have shown poor performance due to low suicide base rate.
- The application of suicide risk stratification is not recommended considering the poor predictive validity, insufficient corresponding evidence-based treatment, and possible negative clinical impact.
- Instead of focusing on known demographic or clinical risk factors, a thorough needs-based approach is suggested for all service users in need.

Suicide is a public health priority. According to the World Health Organization, approximately 800,000 people die by suicide around the world every year. It occurs throughout the lifespan and is a leading cause of death globally, especially in younger populations. Nevertheless, in many countries, suicide rates tend to be higher in older populations. Furthermore, the fact that there are approximately twenty times more suicide attempts than suicide death depicts an even more critical situation.

Suicide prevention has long been perceived to be associated with the identification of risk and protective factors and related management. In clinical practices, suicide risk assessment is often adopted based on demographic factors or via validated questionnaires. The results are commonly expressed in terms of high, medium, or low risk when attempting to stratify patients into different risk categories. Although consensus on assessment procedures and evidence to support the impact of risk stratification remain substantially insufficient, many have attempted to elaborate on the prediction of suicide based on risk assessment and stratification. Common indicators to evaluate the performance of suicide prediction include sensitivity, specificity, and positive predictive value (PPV), with the last, likely being the most critical measure of accuracy.

Recently, a series of research studies, including several systemic reviews and meta-analyses, have challenged the idea of suicide risk stratification. A comprehensive meta-

analysis of 3,428 risk factors across 365 studies by Franklin et al. indicated consistent inaccuracy and weakness of all factors studied in suicide prediction and the allocation of further interventions over the past 50 years. Similar conclusions were drawn by Large and colleagues when reviewing seven meta-analyses targeting psychiatric patients or those with self-injurious behaviors. Even among those with suicide ideation, which commonly raises the greatest concern in clinical judgement, a suicide risk as low as 1% per year was estimated by one of the meta-analyses included.

Besides focusing on individual factors, there have also been various attempts to integrate demographic and clinical factors in order to develop suicide prediction models (SPMs), but the diagnostic accuracy remains disappointing. Two meta-analyses reviewed by Large et al. found only 5% of patients identified as high risk would die by suicide, while almost half of those who committed suicide were previously categorized to be in the low-risk subgroup, demonstrating low positive predictive value (5%) as well as low sensitivity (50%). Some attributed these unsatisfying results to the limitations of population selection or statistical methods. Nevertheless, even with prosperous advances in large health care databases and machine learning techniques, a 2019 meta-analysis by Belsher et al. showed poor predictive validity across different risk groups and analytic methods over the past decades. In their prediction modeling simulations, the PPVs were mostly less than 1%, suggesting nearly 100

false positives for every true positive identified. It required a suicide-mortality rate five times greater than that of the general population (approximately 20 per 100,000) to generate a PPV over 1%. Consistently low PPVs were found in a hypothetical near-perfect model with both sensitivity and specificity at 0.99 – they would be 2% and 33% when the suicide mortality rates are assumed to be 20 times and 250 times greater than that of general population, respectively. The findings also implied confined advancement in further research of SPMs since the inherent limitation of PPV is due to low suicide base rates. Significant increases in the power of statistical discrimination will be necessary if the development of new predictive methods is intended.

Therefore, present evidence appears to suggest against suicide risk stratification and its application as practice guidance considering not only the poor performance of suicide prediction models, but also a dearth of research illustrating the possible impact of its clinical use. Potential negative effects of wrongly identifying patients as at risk include stigmatizing the individuals and jeopardizing their career, along with ethical and legal concerns for the clinicians as there are few evidence-based intervention strategies. Due to poor predictive value, an intervention will only be feasible if it is benign and can be widely accepted. However, if certain interventions do exist, it should be applied to all populations since more than half of the suicide deaths are previously not identified as at risk. Targeting only those at high risk suggest a possible deprivation of treatment options for those classified as low risk.

Hence, in contrast to the risk assessment approach, a needs-based approach was proposed, emphasizing the importance of sympathetic and efficient patient-clinician interactions, valuing the patient's current needs, and the negotiation of a management plan involving both the patient and the family and/or friends. Active interventions for common modifiable factors were also emphasized and included mental illness, substance use, physical illness, socioeconomic distress, and interpersonal conflicts. The approach was incorporated into the guideline of long-term management for self-harm

published by the UK's National Institute for Health and Clinical Excellence, in which it was recommended to take into account service users' needs while risk assessment for further suicide or self-harm prediction was not favored.

In conclusion, the present evidence indicates that the best approach to the management of suicide risk in clinical practice exists in benign communication and distress reduction for all patients in need, instead of assessing nomothetic risk factors and assigning the patients to various treatments according to risk stratifications.

### For further reading:

*Belsher BE, Smolenski DJ, Pruitt LD, Bush NE, Beech EH, Workman DE, Morgan RL, Evatt DP, Tucker J, Skopp NA. Prediction Models for Suicide Attempts and Deaths: A Systematic Review and Simulation. JAMA psychiatry 2019*

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## HOW TO ASSESS QUALITY OF CARE FROM THE CLIENTS' PERSPECTIVE? A CONCEPTUAL FRAMEWORK

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### Key highlights:

- Experienced quality of care is a process of expectations before, during, and after an assessment in the context of receiving care.
- Experiences occur in a care environment mainly within the interactions between the client, staff and informal caregivers.
- Experienced quality of care can be assessed in three domains, including focused on the experience, the impact on the client's health status, and the level of satisfaction.

In 2016, the Dutch government introduced a new national taskforce "Dignity and Pride" aiming to improve quality of care in nursing homes, accompanied with a new quality guideline on how to maintain and improve quality of care in nursing homes [1]. This guideline focuses on person-centered care and relationships, well-being, safety and learning from each other. It stresses the importance of incorporating the client's perspective when monitoring and improving quality of care and recommends focusing on both the client's experiences as well as the client's level of satisfaction. Similar developments are occurring in other countries as well. This is in line with the ongoing culture change in long-term care (LTC), where it strives for a holistic approach, incorporating not only the professional, but also the client's perspective.

To improve quality of care, it is important to define it from the client's perspective. In the early 1960s, Donabedian already said that quality of care does not have one clear definition and depends on the context and perspective in which it is being delivered [2]. Additionally, care is not a product but a type of service delivery. Care delivery differs for each client and is considered complex, interactive and dependent on the time and context in which it is delivered [3]. This makes it even more challenging to monitor quality of care. Therefore, our study aimed to conceptualize quality of post-acute and long-term care for older people as perceived by clients. The article has

recently been published in the *Journal of the American Medical Directors*.

In order to conceptualize experienced quality of care, we adopted an iterative approach in which we explored the literature and consulted experts. The research team extracted information from relevant articles from health and service sciences literature in order to identify common elements, leading to the development of a new framework of experienced quality of care. Experts on quality of LTC were consulted to provide feedback on the framework several times. This iterative approach resulted in the development of the INDIVIDUALLY Experienced QUALITY of Long-term care (INDEXQUAL) framework.

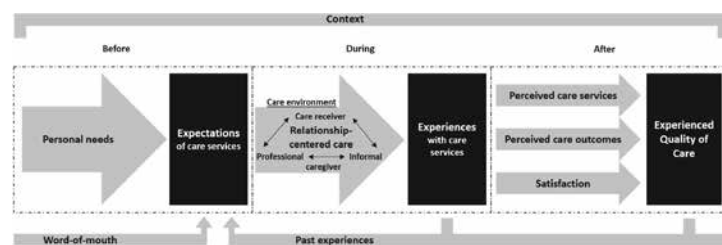


Figure 1. INDEXQUAL Sion et al (In Press)

INDEXQUAL assumes that care provision is a type of service delivery, and therefore a process consisting of before, during, and after. The framework presents the process of a client's experience when receiving care within a certain context. Expectations occur before, experiences during and after an

assessment receiving care. The context of the care experience consists of the setting in which care is delivered and the characteristics of the client receiving care. Expectations are formed before care delivery by personal needs, past care experiences, and word-of-mouth from others[4]. This is followed by an experience consisting of interactions between the actors in the caring relationships. INDEXQUAL illustrates that relationships and interactions between clients, professionals and informal caregivers highly influence care experiences. Therefore, the framework has adopted relationship-centered care as the main concept from which care is being delivered[5]. Lastly, the care experience is assessed on three domains: focused on what happened, the impact on the client's health status and the level of satisfaction. Eventually, these three domains provide insight into how care delivery is experienced.

The INDEXQUAL framework differs from existing frameworks as it places interactions between the client's formal and informal caregivers at the core of care experiences. It acknowledges the client's experiences consist of more than satisfaction and it takes into consideration that care delivery is a process over time. INDEXQUAL provides a more holistic view of experienced quality of LTC from the client's perspective and can be adapted and used to monitor experienced quality of specific LTC settings, such as nursing homes. Additionally, it may support quality improvement initiatives and enhance transparency.

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### BEHAVIOURAL DISORDERS IN DEMENTIA: A CASE OF VISUAL HALLUCINATIONS IN LEWY BODY DEMENTIA TREATED WITH MEMANTINE

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#### Key highlights:

- Behavioral disorders are part of the dementia syndrome accompanying nearly 90% of all cases of dementia and are a major clinical challenge and a burden for the caregiver
- Dysregulation of the hypothalamic -pituitary -adrenal stress axis is one the most accredited hypothesis: imbalanced production of dopamine leads to delusions while serotonin imbalance is responsible for depressive mood
- The first approach to behavioral disorders should be treating somatic or environmental causes, and non-pharmacological measures, which include memory therapy, ergotherapy, music therapy, physical exercise
- Among recommended drugs for behavioral disorders are AChE-inhibitors and NMDA receptor blockers (in Alzheimer and Lewy body dementia), antipsychotics such as risperidone and antidepressant such as citalopram
- Visual hallucinations are a core clinical features in Lewy body dementia
- Visual hallucinations in LBD could be treated with AChE-I and a positive effect with memantine has been described in the literature

**BACKGROUND:** Behavioural disorders which develop in the course of dementing illness are a broad spectrum of symptoms, which include aggressiveness, delusions, agitation, affective disorders, apathy, and disinhibition. They have been variously called: "behavioral disorders in dementia", "non-cognitive-manifestations", "neuropsychological symptoms of dementia" and represent a major clinical challenge in most people affected by dementia, and a major burden for the caregiver. Possible treatments include non-pharmacological and pharmacological measures. In the first group are memory therapy, ergotherapy, music therapy, and physical exercise. While pharmacological treatments include: AChE-inhibitors such as galantamine, donepezil, rivastigmine, and the NMDA receptor blocker memantine for Alzheimer dementia and LBD. Moreover, risperidone is recommended as a first-choice antipsychotic against agitation and hallucinations in dementia, while citalopram can be used for depression. However, somatic causes and medical conditions such as pain, metabolic disorders, and infections have to be ruled out and eventually treated before initiating medication. The pathogenesis of behavioral disorders is believed to be in the dysregulation of the hypothalamic -pituitary-adrenal

stress axis: imbalanced production of dopamine can lead to delusions while serotonin imbalance might be responsible for depressive mood. Among behavioral disorders, the most common are apathy and depression (50-90%), while hallucinations and delusions, although less frequent, are often the cause of seeking medical attention. Of course, the classification of different types of dementia is also important and usually fits a particular pattern: this is especially the case of Lewy body dementia (LBD) where well-formed visual hallucinations are one of the core clinical diagnostic features. For the revised criteria for the diagnosis of LBD see also the Diagnosis and management of dementia with Lewy bodies. Fourth consensus report of the DLB Consortium Neurology on June 7, 2017

**CASE PRESENTATION:** A 79-year old woman was taken for medical attention for visual hallucinations which had started three months before and were described as persistent and irremovable stains on the house floor, which she would obsessively try to clean up without success. In her past medical history, she had suffered a spontaneous subarachnoid hemorrhage in the left frontal area a few years before and was on pramipexole for restless leg syndrome.

BEHAVIOURAL DISORDERS IN DEMENTIA: A CASE OF VISUAL HALLUCINATIONS IN LEWY BODY DEMENTIA TREATED WITH MEMANTINE, *continued on next page*

The neuropsychological evaluation displayed significant and fluctuating attention deficit. Neuroimaging showed marked vascular signs. An FDG-PET brain scan revealed significant hypometabolism in the left parieto-temporal lobes and mild hypometabolism in the left occipital region. Reduced hypometabolism was also seen in the left frontal area associated with the previous subarachnoid hemorrhage (see FDG PET scan images below). According to the DSM-5, she was diagnosed with “major neurocognitive disorder by probable Lewy body disease”. Non-pharmacological measures were ineffective on the visual hallucinations and because of her well-known sensitivity to neuroleptics, a pharmacologic attempt was made with a rivastigmine patch (starting dose 4.6 mg which was raised to 9.5 mg and then to 13.3 mg). However, symptoms worsened and the patient was given quetiapine, which had no significant effect. We decided to stop quetiapine and to switch rivastigmine to memantine. When memantine was increased at the dose of 20 mg behavioral symptoms finally ameliorated.

**CONCLUSION:** Behavioral disorders are part of dementia syndromes, and in the case of LBD, may even be a core diagnostic feature. Behavioral symptoms in dementing illness, according to the existing literature and guidelines, should be first approached by treating somatic or environmental causes, and with non-pharmacological measures. Among pharmacological treatments, AChE-I and memantine have indications in cognitive decline in Alzheimer dementia and LBD. In the case of LBD, a positive effect on visual hallucination has been described in the literature with the use of memantine, similar to the case presented. This might be particularly favorable given the well-known sensitivity to neuroleptics of LBD patients.

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### EVALUATING A DEMENTIA MEMORY SERVICE FROM TWO SIDES OF THE COIN: AN ACADEMIC AND CLINICAL PERSPECTIVE

Dr Clarissa Giebel and Cassie Eastham

University of Liverpool, NIHR CLAHRC NWC

#### Key highlights:

- Working jointly with clinicians and academics as equal partners improves learning and knowledge exchange
- Service evaluations are a great way to assess existing and implemented services, and derive learning from these
- In order to address the needs of different patient groups (i.e. dementia), we researchers can benefit from being immersed in active

Young-onset dementia (YOD) affects approximately 40,000 people in the UK alone. If someone has a diagnosis of dementia, and is below 65 years of age, they are diagnosed with YOD. But that doesn't mean it only happens to people in their 60s. There are people diagnosed with YOD in their 40s (<https://www.elder.org/the-elder/dementia-care-tracey-shorthouse-living-with-early-onset-dementia/>). And in their 30s. And even in their 20s in extreme cases (<https://www.express.co.uk/news/uk/831214/Mother-early-onset-Alzheimer-dementia>).

There is obviously lots of variation in lifestyle between one's 30s and one's 50s for example. People might have a busy career and job, might have financial restraints and a mortgage, might have children to care for, and sometime their parents to care for (as well). So, people lead busy lives. If we try and compare this to someone in their 80s for instance, they will be retired, might be more frail and have at times limited mobility, and are less likely to be caring for someone (unless it is their spouse).

So, receiving a diagnosis of dementia for someone in their 30s or 40s can have a much different impact than for someone in their 80s. But it's not only the person living with dementia that is affected by it, but also their families. It can come as a great shock if your spouse gets diagnosed so early in their lives (<https://www.theguardian.com/lifeandstyle/2011/nov/21/picks-disease-early-onset-dementia>). When caring for a spouse with YOD, the family care giver is most often

employed and has other responsibilities. In some cases, the family care giver may decide to give up their job to support their loved one with YOD full-time.

To see whether a local memory service in the North West of England was addressing the needs of people with YOD and their families, we worked together with an occupational therapist from the memory clinic and people affected by YOD. Being a researcher, it was a great experience supporting the clinician to learn about her, support her, and evaluate her service. Often, we researchers might only think of working within the research environment, but being involved in such an applied service evaluation with a clinician, which was guided by the interests of the NHS Trust, was really insightful. It was also a good way of getting to know the local memory service better, and how it works. Often, we might only research services without being truly emerged in them. So this service evaluation allowed me as a researcher to link-up with local clinicians in the field of dementia, and make sure that their project generated academically-sound evidence, which would be able to support them in the future to make changes and potential improvements to their service. These were my experiences of working together on this YOD project, and what follows are Cassie's experiences.

(Cassie) Taking part in a Trust audit of the NICE clinical guidelines for dementia, *I (Cassie Eastham)* was asked the question of what do we do for people living with young onset dementia? I started thinking. As a service we accept

## AROUND THE WORLD

EVALUATING A DEMENTIA MEMORY SERVICE FROM TWO SIDES OF THE COIN: AN ACADEMIC AND CLINICAL PERSPECTIVE, *continued from page 17*

referrals for people experiencing memory problems regardless of their age, but is that enough? And what happened to people after we had made a diagnosis? The questions stayed with me as I went about my usual work. I had also recently realised that I wanted to incorporate research into my professional practice, but I was still trying to figure out what this might involve.

With near perfect timing, the Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC) gave me the opportunity to investigate and evaluate just how well our service was meeting the needs of younger people and their families. It also supported me to develop my practical research and leadership skills, taking me far out of my comfort zone along the way. Having to put together a steering group of interested individuals and agencies, presenting the project to senior leadership team meetings and taking a poster presentation to the UK Dementia Congress, all contributed to building my confidence and identity as a clinical researcher.

The relationships that I have developed with other organisations have led to us being able to implement new projects in partnership and to start improving the availability of activities and support for people living with young onset dementia. Within this, I have been able to use the knowledge

and skills that I learned through the programme to build evaluation into the projects that we are implementing. Most importantly of all, I have been able to see the results of listening to the people who have used our service and started to make things better for those who will use it in the future.

So, all in all, both Cassie and I have benefited from working on this service evaluation together, sharing knowledge and experiences and learning from being immersed in the other setting (academia and clinical practice). I am not sure how common this very applied work is in other countries, but I hope this might spark some ideas to help apply research in the real-life settings and address the needs and interests of local hospitals and clinical settings, and those affected by dementia and other conditions.



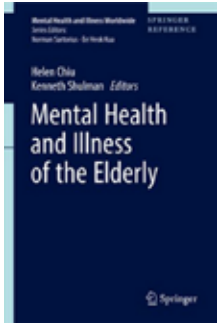
Dr. Giebel is a dementia researcher specializing in everyday functioning and enabling people with dementia to stay in their own home for as long as possible. In her current role at the University of Liverpool and at the NIHR CLAHRC NWC, she particularly focuses on health inequalities in people with dementia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

### A BRIEF BOOK INTRODUCTION ON THE MENTAL HEALTH AND ILLNESS OF THE ELDERLY

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Secretary-General, Taiwanese Society of Geriatric Psychiatry



*The Mental Health and Illness of the Elderly* is one of seven volumes on Mental Health and Illness Worldwide. The editors, Helen Chiu (Hong Kong) and Ken Shulman (Canada), are top experts from Hong Kong and Canada and they invite outstanding authors from different countries of the world.

Although published in 2017, I still want to make a brief introduction since it is a book worth reading. This book is divided into three sections: The Global Challenge of Aging Populations; Diagnosis and Assessment; and Treatment and Services. It emphasizes on a public health and epidemiological perspective, and also exhibits recent progress in research and service delivery.

As is known to all, aging is an inevitable and irreversible decline in viability and an increase in vulnerability. One of the distinctive viewpoints in this book is the chapter "Successful Aging". Although human aging is associated with progressive physical and cognitive weakening, recent research recognized enhancement in psychological well-being across the life span. There is a growing interest in exploring strategies to achieve successful aging.

Moreover, physiological changes with aging render us more susceptible to various diseases. The common mental disorders in the elderly, including neurodegenerative disorders, delirium, mood and anxiety disorders, and schizophrenia were embodied in this book. Physical comorbidity was also addressed because it was a common problem in older adults. Considering the complexity of prescribing medications for elderly patients, the editors assigned two chapters to discuss pharmacotherapy for mood and anxiety disorders and dementia.

Another highlight of this book comprises the themes of mental capacity and health economics of service. In the chapter of "Capacity Assessment", the author demonstrates how decent capacity assessment can support legal capacity and other related human rights. Through illustrations in "Elderly Services, Community Care, and Health Economics of Service", readers can understand the basics of health economics that determine which intervention or service offers the best value for money.

In summary, this book integrates current knowledge in mental disorders among the elderly, while underlining the necessity of integration of medical and healthcare professionals in mental health care.

Available on <https://www.springer.com/kr/book/9789811024122>

### ENGAGING FOR CHANGE IN GERIATRIC PSYCHIATRY: REPORT FROM THE 2019 AAGP ANNUAL MEETING IN ATLANTA

Karen Reimers, MD, FRCPC

Adjunct Assistant Professor, University of Minnesota, USA

#### Key highlights:

- The 2019 AAGP Annual Meeting, with the theme of “Engage for Change: Preparing and Partnering for the Future of Geriatric Mental Health” was held from Friday, 1 March 2019 - Monday, 4 March 2019 at the Hilton Atlanta, Georgia.
- The meeting was a resounding success covering a range of topics, many related to policy and advocacy in geriatric psychiatry
- IPA members are invited to attend the AAGP 2020 Annual Meeting: Translating Research Evidence into Clinical Geriatric Mental Healthcare, to be held at the Grand Hyatt in San Antonio, Texas from 13-16 March 2020



The American Association for Geriatric Psychiatry (AAGP) was founded in 1978 to foster the specialty of geriatric psychiatry and promote the delivery of quality mental health care to the aging population. Today, the AAGP is an established membership association of nearly 2,000 geriatric psychiatrists and other health care professionals in the United States, Canada, and abroad, dedicated to the mental well-being of older adults.

The 2019 AAGP Annual Meeting, with the theme of “Engage for Change: Preparing and Partnering for the Future of Geriatric Mental Health” was held from Friday, 1 March 2019 - Monday, 4 March 2019 at the Hilton Atlanta, Georgia. A special Full Day Event was also held on Thursday, 28 February 2019, which included a full-day practice workshop, “Understanding a Career in Geriatric Psychiatry, from the Basics to the Complex”. Further workshops and special

sessions included a full day Geriatric Psychiatry Board Review Course, a Geriatric Psychiatry Fellowship Program Training Directors’ Workshop, and a Neuroscience Teaching Day.

Plenary sessions at the main meeting included a variety of topics, mostly with an advocacy and policy focus, including Physician Leadership in the Opioid Epidemic and Changes in Health Policy at the Substance Abuse & Mental Health Services Administration (SAMHSA).

Throughout the AAGP Annual Meeting, research of the AAGP membership was highlighted through many CME sessions, including New Research and a Late Breaking Poster Session. Presenters included several IPA members and other leaders in the field of dementia research. Presentations covered major mental disorders of late life, clinical pharmacotherapy and psychosocial treatments for late-life mental illness, age-related changes in pharmacologic response, behavioral

ENGAGING FOR CHANGE IN GERIATRIC PSYCHIATRY: REPORT FROM THE 2019 AAGP ANNUAL MEETING IN ATLANTA, *continued from page 20*

interventions for managing agitation and other dementia-related behavioral issues, complementary treatment approaches, ethical issues such as advance directives and end-of-life care, culturally appropriate care to specific diverse populations, concepts of successful aging and quality of life, key issues in aging and mental health policy, applying the latest research methodologies and findings to clinical cases, and the role of caloric restriction in brain and neurodegenerative and vascular disorders, among many others.

The AAGP is proud of its robust member participation in supporting the AAGP Scholars Program, an opportunity for Psychiatry residents and medical students interested in a career working with older adults. Returning AAGP Honors Scholars and other early career members presented their work in oral presentations as well as a special Early Investigator Poster Session with Poster Rounds.

AAGP's various committees, caucuses, and interest groups are the lifeblood of the organization and member participation is an important step towards advocating for the future of the field and the health and care of geriatric patients. AAGP

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committees convening at the 2019 meeting included the International Medical Graduate (IMG) Caucus, the Lesbian, Gay Bisexual and Transgender (LGBT) Members Interest Group, Public Policy Caucus, Retirement Age Caucus, Teaching and Training Committee, and Women's Interest Group, among others.

Overall the 2019 AAGP meeting in Atlanta was a resounding success. IPA members are encouraged to save the date for the 2020 Annual Meeting: Translating Research Evidence into Clinical Geriatric Mental Healthcare, to be held at the Grand Hyatt in San Antonio, Texas from 13-16 March 2020.

### For further reading:

American Association for Geriatric Psychiatry website is <https://www.aagponline.org>

Full 2019 AAGP Annual Meeting Program is at <http://www.cvent.com/events/aagp-2019-annual-meeting/custom-38-15f2fc68a681428cb46dfa6dc8a40ed7.aspx?dvce=1>



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