IPA Bulletin

INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION • BETTER MENTAL HEALTH FOR OLDER PEOPLE

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WHAT'S INSIDE

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PRESIDENT'S MESSAGE – RAIMUNDO MATEOS

Dear colleagues,

Relatively little time has passed since the previous issue was published and yet we have important news to comment on activities carried out by the Executive.

According to the IPA bylaws, this year corresponds to hold elections for the renewal of the Executive and Board of Directors (BOD). After the corresponding electoral process, three positions of the Executive have been renewed

- William Reichman, as President-Elect
- Huali Wang has been re-elected for a second term as Secretary
- Kate Zhong has been elected as Treasurer

Welcome to the new members of the Executive!

Voting is now open for three new members of the Board of Directors. Please see http://www.ipa-online.org/ for candidate information and to cast your vote.

And in the next newsletter we will communicate the names of the three members elected to the BOD.

The IPA collaborates this year with the Royal Australian and New Zealand College of Psychiatrists in a joint meeting that will take place in Queenstown, New Zealand, 8-10 November 2017. This bulletin details the program of workshops that the IPA will deliver on 8 November. The high quality of the program and the tourist attraction of the venue are two powerful reasons for IPA members to organize now their trip to Queenstown!

Contacts to hold the congress of the IPA in Europe continue at a good pace. This will be an important topic of the agenda of the next face to face meeting of the BOD, which will take place in London on 16 July 2017.

It is time to start considering options for the 2019 congress. We encourage IPA leaders to submit proposals, with the assurance that they will all be studied with great interest.

In the previous newsletter I mentioned the complaint that IPA, together with other international associations, had made to WHO on the project of removing the dementias of the group of mental illnesses in the ICD-11. It is very gratifying to share it with the

PRESIDENT'S MESSAGE, *continued on next page*

PRESIDENT'S MESSAGE, *continued from page 1*

"psychogeriatric world" that this effort has borne fruit, as detailed in the relevant news of this newsletter. (see page 7.)

An important part of the effort of the Executive and the Secretariat has been dedicated to International Psychogeriatrics (IPG), the IPA 'flagship' publication. With great satisfaction we announce that Prof. Dilip Jeste will be the new Editor-in-Chief. His extensive experience and research creativity, and his specific experience as a journal editor, are the best guarantee that IPG will continue experiencing a significant and rapid growth.

At the same time that we give the warmest welcome to Dr. Jeste, we want to show our immense gratitude to the two editorial teams that have preceded him, led by Prof. Nicola Lautenschlager and Prof. David Ames. These teams should be recognized for the growth that IPG has experienced in recent decades. Specifically, I want to thank both leaders for their deep loyalty to the IPA and their support to facilitate a process of smooth transition.

The second issue of the *Bulletin* led by the new editorial team is loaded with interesting themes, some completely new; for others, such as the Meeting Centers, an update in the 21st century of a 'classical' European program. May I remind you that any time you have in mind something that you like to share with other IPA members, consider to make a contribution to the *Bulletin*.

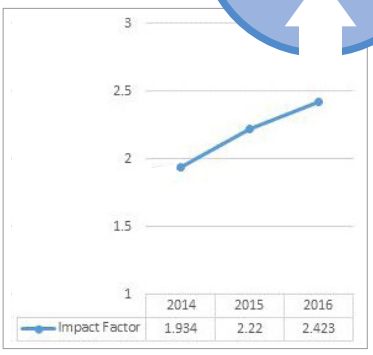
Again, to all, the most cordial invitation to take part in the principal activity of the IPA of this year. See you in Queenstown!

Raimundo Mateos
IPA President

JUST RELEASED:

Impact Factor
2.423
in 2016

Clarivate Analytics has released the 2016 Impact Factors and International Psychogeriatrics saw another increase this year – a **9% rise from 2015 Impact Factors of 2.220 to 2.423 in 2016**.



EDITOR'S NOTE – TZUNG-JENG HWANG

The *IPA Bulletin* offers a platform for all members to share experiences, exchange ideas, and cultivate new innovations. The editorial team is now collecting more ideas to make this platform better, such as modifying the format and design of the *Bulletin* to make it more attractive and richer in substance. I want to thank the previous Editor-in-Chief of the *IPA Bulletin*, Dr. Nicole Stocking-Aho, for her kind support in keeping the continuous good quality of the *Bulletin*. She shared with us many precious experiences. I am also deeply grateful to our associate editors, who offer their time and wisdom to provide updated knowledge and wonderful thoughts for our members.

In this issue, President Mateos makes several important announcements, including renewal of the Executive and BOD, appointment of new Editor-in-Chief of *International Psychogeriatrics* (Prof. Dilip Jeste), collaboration of the 2017 IPA Meeting with the Royal Australian and New Zealand College of Psychiatrists in Queenstown, New Zealand, success of the IPA's efforts to stop the removal of dementia from the diagnostic group of mental illness in the ICD-11, etc. These news and results are encouraging.

There are four fascinating articles in "**Research and Practice**" and three in "**Around the World**".

In "**Research and Practice**":

Dr. Herrmann (Canada) reviews several of the most up-to-date and significant findings on electroconvulsive therapy (ECT), "one of the most important tools available to geriatric psychiatrists to treat severe refractory mood disorders." For instance, he concisely summarizes the key results of the PRIDE studies in 2016, regarding the efficacy of ECT among elderly unipolar depressives at high risk for relapse. Make sure to read until the end, for the "coolest study of 2016"!

Dr. Giebel (United Kingdom) provides an in-depth commentary on the "implications of effective differential diagnosis" of dementia, focusing on the impact of specific symptoms that vary across subtypes. After reviewing differences in functional dependence, cognition, and behavioral issues, she proceeds to explain the effect that these differences have on care management.

Dr. Arsenijevic and Prof. Groot (The Netherlands) update us on the "PRO HEALTH 65+Health Promotion and Prevention of Risk – Action for Seniors" project, which evaluates two complex community-based interventions for physical and mental wellbeing among the elderly. The first, physical activity on prescription (PARS), is the subject of a systematic literature review with meta-analysis, with results that vary across different diagnostic groups. The second, "household help," is covered by a longitudinal observational study with rigorous statistical analyses, focusing on its effects on loneliness.

EDITOR'S NOTE, *continued on next page*

IPA BULLETIN CALL FOR EDITORS

INTERESTED IN JOINING THE *IPA BULLETIN*?

The *IPA Bulletin* is looking for editors to join the Editorial Panel for 2017. To learn more visit the IPA website.

Open Positions

Deputy Editor for Around the World

Assistant Editors for Research and Practice

Topics of Focus:
Geriatric Medicine
Social Work
Primary Care
Occupational Therapy
Psychopharmacology
Epidemiology
Imagine
Other Topics TBD

Assistant Editors for Around the World

Application Information

Click here to view the application.
Submit to IPABulletin@ipa-online.org.

Questions?

Please contact us at IPABulletin@ipa-online.org.

EDITOR'S NOTE, *continued from page 3*

Dr. Reimers (United States) highlights the need for geriatric forensic evaluations, including those regarding decision-making capacity, guardianship, consent to research, elder abuse, competency to stand criminal trial, and other "medicolegal" issues. She provides a short and sweet list of ten best practices for geriatric forensic evaluations, and recommends two freely available resources applicable across countries.

All four articles are helpful in daily practice and care. I encourage you to read and learn these important findings!

In "**Around the World**":
Prof. Dröes (The Netherlands) reports on behalf of the MEETINGDEM Consortium, which convened after the successful implementation and dissemination of a dementia care project across Europe for the past three years. The evidence-based "Meeting Centers Support Programme (MCSP)" model provides services to both people with dementia and their caregivers, and has been executed in the Netherlands, Italy, Poland, the UK, and Spain. At the end of her piece, Prof. Dröes invites all who would like to receive updates or get involved in the program to connect.

Ms. Tu (United States) outlines a highlighted topic at this past April's Alzheimer's Disease International conference in Kyoto: "dementia-friendly communities." She provides an up-to-date definition, lists major examples of related projects (including dementia cafés, educational programs, media projects to raise awareness, community watches, and employment opportunities), consolidates keys to success for these initiatives, and recommends further resources for all those interested. From lower- and middle- to high-income countries, all societies are getting involved in the movement toward inclusion and empowerment of people with dementia.

Dr. Valzolgher (Italy) briefs us on the Italian Psychogeriatric Association (AIP) National Congress, which took place in Florence this past March. With the positive approach embodied by the meeting's theme, "Psychogeriatric: clinical practice, research, hopes", she describes opportunities to learn and build community, important studies shared, and the election of AIP's Directory Board at the Congress. It is highly encouraging to read about the engagement of a broad range of people, particularly non-medical professionals, as well.

It is fascinating to know what is happening around the world. The IPA is the global leader in aging mental health, with members from diverse backgrounds and areas of expertise. The *IPA Bulletin* is an ideal platform for people around the world to exchange ideas and share experiences for the common mission of enhancing mental health for the elderly. I cordially invite more members to contribute their thoughts and experiences to the *Bulletin*! You can reach us at IPABulletin@ipa-online.org.

Tzung-Jeng Hwang, MD, PhD, MPH
IPA Bulletin Editor-In-Chief

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Faculty of Psychiatry of Old Age

CONFERENCE 2017

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- 4th International Conference on Capacity - Controversies and the Cutting Edge
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- Late Life Mood Disorders

To register for the conference, or for more
please visit: https://www.ranzcp.org/Publications/Events/FPOA-Conference-2017/About-the-event.aspx

In association with

IPA International Psychogeriatric Association
Better Mental Health for Older People

CONGRATULATIONS AND WELCOME TO OUR NEW IPA EXECUTIVE BOARD MEMBERS:

William Reichman
President-Elect

Dr. William Reichman, an internationally-known expert in geriatric mental health and dementia care, is President and Chief Executive Officer of Baycrest, one of the world's premier academic health sciences centers focused on aging, seniors care and brain function. Dr. Reichman is also Professor of Psychiatry on the Faculty of Medicine at the University of Toronto. He has advised numerous levels of government in the United States, Canada and China on the impact of an aging society on health care demand.

Kate Zhong
Treasurer

Dr. Kate Zhong is the Chief Strategy Officer for the Global Alzheimer's Platform (GAP), a foundation devoted to improving and accelerating clinical trials for Alzheimer's disease. Prior to joining GAP, Dr. Zhong was the Senior Director of Clinical Research and Development for the Cleveland Clinic Lou Ruvo Center for Brain Health where she led the development of the research program and established the center as one of the largest and most active clinical trial facilities for memory disorders in the country.

Huali Wang
Secretary

Dr. Huali Wang is the Chair, Clinical Research Division and Associate Director, Beijing Municipal Key Laboratory for Translational Research on Diagnosis and Treatment of Dementia. She is also the Associate Director, Dementia Care & Research Center, Peking University Institute of Mental health. Dr. Wang has been closely involved in and served as one of the founding members and Secretary-General of the Chinese Interest Group of Chinese Society for Psychiatry (CPIG), an IPA affiliate.

HAVE QUESTIONS ABOUT YOUR IPA MEMBERSHIP?

IPA members receive an electronic subscription to *International Psychogeriatrics*, discounts on IPA meetings, and access to online educational materials. You can join or renew via the IPA Members Area of our website.

If you have questions about IPA or your membership, please contact the IPA Secretariat at **info@ipa-online.org**.

IPA BOARD OF DIRECTORS ELECTION

GENERAL INFORMATION

The International Psychogeriatric Association (IPA) is governed by a Board of Directors consisting of 11 members. In addition to the five officer positions, there are six additional Directors. Each Director is elected by the voting membership to a four-year term. Directors are eligible to serve a maximum of two terms. There are three seats open for election on the Board of Directors. Those elected to these seats will serve a term from 2017-2021. The term begins and ends following the IPA International Congress each year. Those elected will be required to attend the 2017 Conference which will take place 8-10 November 2017.

BOARD OF DIRECTORS RESPONSIBILITIES

Members elected to the IPA Board of Directors are expected to:

- Attend all Board meetings via conference call, and participate by preparing for and contributing to the meeting. In addition Board members are expected to attend at least one IPA meeting per year. Travel and expenses for meetings are not funded by IPA.
- Actively dedicate a minimum of 40 additional hours per year to leading IPA.
- Contribute to policy and strategy development and decision-making.
- Participate on committees or task forces when appropriate and assigned.
- Advance the mission, vision, and goals of IPA in their country.
- Encourage colleagues to become IPA members.
- Advise the Board of Directors on matters of importance within their country and region.
- Serve as a liaison with organizations similar to IPA in their country and region in order to develop mutually beneficial relationships and affiliation to IPA.
- Expand IPA's relationships with Pharma and New Markets.
- Maintain membership in good standing by regularly paying dues.

CANDIDATE INFORMATION AND VOTING

Voting is now open for the 2017 IPA Board of Directors Election. The candidates are listed below. IPA members can view candidate information and vote by signing in to the IPA Members Area of the website. Voting will close on 15 July 2017 at 11:59 pm CDT.

Tzung-Jeng Hwang
Taiwan

Wendy Moyle
Australia

Carmelle Peisah
Australia

Kiran Rabheru
Canada

WHO REVERSES DEMENTIA TO THE CHAPTER OF MENTAL AND BEHAVIORAL DISORDERS IN ICD-11

Raimundo Mateos
IPA President

The previous issue of this *Bulletin* reported on the WHO proposal for all categories related to dementia to be categorized in the ICD-11 chapter on Diseases of the Nervous System.

IPA joined a large number of international scientific and professional associations protesting the initiative. Prominent leaders of the IPA contacted leaders of the process of development of ICD-11 and the president of the IPA sent a letter of complaint to the director of the WHO Department of Mental Health and Substance Abuse, detailing the reasons against such an initiative. IPA also contacted affiliated associations and encouraged them to express their concern to the national representatives of the WHO in their country.

We are very pleased to make known to the whole psychogeriatric community that these efforts have been successful and the WHO has reversed its decision. This was formally advised to the IPA President in the recently received WHO response letter. Click to see the IPA letter as well as the response from WHO.

In brief, "the current version of ICD-11 categorizes dementia in the chapter on Mental and Behavioural Disorders".

We are delighted by this decision, but above all, we reaffirmed in our mission, and confirms the urgent need for the IPA to continue to exist as an autonomous association, dedicated to improving the mental health of older people and their caregivers around the world.

IPA ANNOUNCES NEW EDITOR-IN-CHIEF OF INTERNATIONAL PSYCHOGERIATRICS

IPA is pleased to announce that Dr. Dilip V. Jeste, MD has been chosen as the new Editor-in-Chief of *International Psychogeriatrics*, the prestigious academic journal owned by the International Psychogeriatric Association (IPA) and currently published twelve times per year by Cambridge University Press (CUP). This is a four year appointment beginning 1 October 2017.

Dilip V. Jeste, MD is a geriatric neuropsychiatrist who specializes in schizophrenia and other psychotic disorders in older adults, as well as positive psychiatry, successful aging, and neurobiology of wisdom. He is the Senior Associate Dean for Healthy Aging and Senior Care, Estelle and Edgar Levi Chair in Aging, Distinguished Professor of Psychiatry and Neurosciences, and Director, Sam and Rose Stein Institute for Research on Aging, at the University of California, San Diego (UC San Diego).

Education and Professional Experience: Dr. Jeste obtained his medical education in Pune and psychiatry training in Mumbai, India. In the US, he completed psychiatry residency at Cornell and neurology residency at George Washington University. He was a Research Fellow and later, Chief of the Units on Movement Disorders and Dementias at the National Institute of Mental Health (NIMH) before joining UC San Diego. There he started a Geriatric Psychiatry program from scratch; today it is one of the largest Geriatric Psychiatry Divisions anywhere.

Research: Dr. Jeste's main areas of research include schizophrenia and other psychoses, pharmacologic and psychosocial interventions, and successful aging. He has been Principal Investigator on a number of research and training grants, and has been funded by the National Institutes of Health (NIH) continuously for 30 years. His work includes clinical, translational, and services research, primarily in the areas of relevance to mental illness, mental

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IPA ANNOUNCES NEW EDITOR-IN-CHIEF OF INTERNATIONAL PSYCHOGERIATRICS, *continued from page 8*

health, and aging. Specific areas of his interest have been late-onset schizophrenia, psychopharmacology, psychosocial interventions for older people with schizophrenia and related disorders, psychosis of Alzheimer's disease, accelerated biological aging in schizophrenia, and sustained remission of schizophrenia in later life. In recent years, he has been promoting Positive Psychiatry, emphasizing mental health and ways of enhancing it through positive traits such as resilience and wisdom.

Publications: He has published 12 books including Successful Cognitive and Emotional Aging (2009), Prevention in Mental Health (2011), and Positive Psychiatry (2015). He has also published more than 625 articles in peer-reviewed journals and 140 invited book chapters. His work has been cited in the Time, Atlantic, NY Times, Washington Post, Wall Street Journal, London Times, Public Radio International, etc.

Training: Dr. Jeste has been involved in research and clinical training of high school students, undergraduates, graduate, medical, nursing, and social work students, fellows, and faculty. He is also passionate about community education.

Editorship: Dr. Jeste served as the Editor-in-Chief of the American Journal of Geriatric Psychiatry from 2001 to 2015. Under his leadership, the journal became the top publication in the field, in terms of the Impact Factor and downloads.

Honors: Dr. Jeste is a member of the National Academy of Sciences, Engineering, and Medicine, and was a member of the NIMH Advisory Council and the inaugural NIH Council of Councils. He was listed in "The Best Doctors in America" and in the Institute of Scientific Information list of the "world's most cited authors"--comprising < 0.5% of all publishing researchers of previous two decades. Dr. Jeste was a Past President of the American Psychiatric Association (APA), the American Association for Geriatric Psychiatry, and the West Coast College of Biological Psychiatry, and Founding President of International College of Geriatric Psychoneuropharmacology. He has received Commendation for Dedicated Service from the Veterans Affairs and awards from NIMH, Society of Biological Psychiatry, APA, Institute of Living, National Alliance on Mental Illness, National Alliance for Research in Schizophrenia and Affective Disorders, American College of Psychiatrists, and Universities of Pennsylvania, Pittsburgh, Cincinnati, and Maryland, and Cornell.

He was recently a TEDMED speaker on the topic of "Aging and Wisdom."

International Psychogeriatric Association (IPA): Dr. Jeste is a Life Member of the IPA. He has given several lectures at IPA conferences, including Raymond Levy Lecture (Beijing, 2014). He received IPA's Award for Service to the Field in 2005.

Other International Activities: Dr. Jeste has strong international interests. As APA President, he established a new APA Council on International Psychiatry to facilitate international collaboration. He has received Honorary Fellowship, the highest honor it bestows, from the UK's Royal College of Psychiatrists; Honorary Professorship from Universidad Peruana Cayetano Heredia, Lima, Peru; Asian Heritage Award for "Excellence in Science, Technology, and Research" from Asia; Visiting Professorship, Royal Australian and New Zealand College of Psychiatrists; Certificate of Honour, Indian Psychiatric Society; Indo-Global Psychiatric Initiative Award for Academic and Administrative Skills; and Award for Significant Contributions in Neurosciences to World Psychiatry, from the Asian Federation of Psychiatric Associations.

Recent Contributions: Dr. Jeste has been widely recognized for his contributions to the scientific community. As the (APA's) President during 2012-13, he spearheaded the process of finalization, approval, and publication of the DSM-5. He also expanded APA's international membership, and focused on Positive Psychiatry.

Dr. Jeste developed the newly launched UC San Diego Center for Healthy Aging, a unique, multi-professional center, breaking the traditional silos of academic disciplines by bringing together best scientists from varied professional backgrounds such as engineering, technology, pharmacy, gerontology, social science, and arts and humanities, to work collaboratively on different aspects of healthy aging.

ECT UPDATE

Nathan Herrmann MD FRCPC
Richard Lewar Chair in Geriatric Psychiatry, University of Toronto and Sunnybrook Health Sciences Centre, Toronto, Canada

ECT remains one of the most important tools available to geriatric psychiatrists to treat severe refractory mood disorders. This past year has seen the publication of a number of important studies that have helped clarify ECT's effectiveness and safety, as well as guide clinicians' treatment plans. While I will highlight what I believe to be several important publications, there are also a couple of useful review articles that summarize new findings related to efficacy and adverse cognitive effects (Geduldig and Kellner 2016; Kumar et al 2016).

Without question, the most notable recent publication on ECT in the elderly was the PRIDE (Prolonged Remission in Depressed Elderly) study (Kellner et al 2016a, Kellner et al 2016b). The first phase of the study was aimed at treating older patients with severe unipolar depression with ECT until remission. The study utilized right unilateral placement (d'Elia), ultra brief pulse stimuli (either 0.25 or 0.3 ms), and three times weekly treatments. Just prior to ECT being initiated, patients were also started on venlafaxine at 37.5 mg, which was then titrated up every three days during the ECT course, until a target dose of 225 mg was reached, or as tolerated. Venlafaxine was added in an attempt to augment acute ECT treatment as well as to ensure patients would enter the next phase of PRIDE already on a therapeutic dose of a potential prophylactic agent. Two hundred and forty patients entered the study and were 69.9 years of age on average, with a mean baseline HAM-D of 31.2 and an MMSE of 27.5. Remission was the primary outcome, and 61.7% met criteria. Response, defined as a decrease in HAM-D by at least 50%, was reached by 70.4%. Including all patients, the mean change in baseline HAM-D was an impressive 19.1 points. The average number of treatments was 7, and there was no significant change in MMSE score pre- and post-treatment. The target dose of venlafaxine was reached by 52% of patients, with average dose for those who didn't meet target being 114 mg. The authors noted that the excellent effectiveness and tolerability were expected based on previous studies of ultra brief pulse unilateral ECT in younger and mixed-age patient populations. Analysis of their results did not lend support to the suggestion that venlafaxine could augment the acute benefits of ECT alone.

In the second phase of PRIDE, all remitters from phase 1 were eligible to enter a 24 week, randomized 2-arm parallel study comparing pharmacotherapy alone with the venlafaxine plus lithium carbonate, or ECT continuation therapy along with venlafaxine and lithium treatment. Lithium was initiated at 300 mg and titrated in order to reach to a serum level of 0.4-0.6 mEq/L. Continuation ECT was administered as an initial, fixed, four treatments in the first month, followed by a "symptom titrated algorithm" which could allow 0-2 treatments per week based on the patient's HAM-D score. After 24 weeks, the mean HAM-D score in the ECT group was significantly lower than the pharmacotherapy only group, while 20.3% of pharmacotherapy only patients relapsed and 13.1% of the combined pharmacotherapy-ECT patients relapsed. This resulted in an odds ratio of 1.7 with 95% CIs 0.6-4.5. The authors concluded that additional ECT beyond traditional treatment end-points, with "rescue" ECT as needed, is helpful and well tolerated for elderly unipolar depressives at high risk for relapse.

The PRIDE studies could not answer all the obvious questions including what the relative contributions of the venlafaxine plus lithium pharmacotherapy were to prophylaxis, or what the optimum maintenance ECT schedule should be. The clinical implications for practice today seem obvious however, and this includes greater use of ultra brief pulse unilateral ECT, consideration of more ECT treatments beyond remission, and the aggressive titration of pharmacotherapy during ECT treatments. The practical implication of this study that must also be considered by hospitals, is ensuring that efficient outpatient ECT services should be available to all ECT patients.

This past year was also a good one for good news about ECT and cognition. Using a sophisticated neurocognitive battery,

ECT UPDATE, *continued on next page*

ECT UPDATE, *continued from page 10*

Mohn and Rund (2016) studied 31 patients pre- and post-ECT and found many improvements, with no worsening in any areas of cognition. Post-ECT scores were highly correlated with residual depressive symptoms. In a much larger study of 199 patients, Kirov et al (2016) looked at cumulative cognitive effects over ten years and found no evidence that even multiple ECTs and ECT courses (including one patient who had 186 treatments!) in any way worsened cognition. What did worsen cognition were age, severity of depression at time of testing, and shorter time since last ECT treatment. Finally in an exclusively geriatric patient population, Dybedal et al (2016), randomized 65 elderly patients to either bifrontal or right unilateral ECT and measured cognition at baseline, with follow-up one week and three months after ECT. Their results suggested that while there were minor differences in the time courses of improvement in some specific cognitive domains, overall there was no differences in the "equally favorable" cognitive outcomes between bifrontal and right unilateral ECT in the elderly. An important caveat is that these studies did not take into account autobiographical memory, which may be specifically impaired by ECT.

In the coolest study of 2016, Zhong et al (2016) randomized 90 adult patients (mean age was only 30.6 years) with treatment resistant depression (TRD) to either full anesthetic doses of ketamine (0.8 mg/Kg), ketamine (0.5 mg/Kg) + propofol, or propofol alone as their ECT anesthetic. The ketamine alone group improved more quickly, had higher remission rates, longer seizures and less cognitive impairment than the other groups. It is important to note that this is not the first study to look at ketamine as an anesthetic agent for ECT, and most previous studies found no specific benefit (beyond the effect of ECT). The authors argue that this study is different, because it included only TRD patients and a higher percentage of bipolar patients, compared to the previous trials. Important limitations are lack of information on the dissociative effects of ketamine and specific tolerability for the elderly. From a clinical perspective, we should probably not be switching to ketamine from propofol yet, but certainly, we should be thinking more about ketamine whenever we are observing unusually short seizure durations and/or when treating TRD and bipolar patients with ECT.

References:

Dybedal GS, et al: Cognitive effects of bifrontal versus right unilateral electroconvulsive therapy in the treatment of major depression in elderly patients. Journal of ECT: 2016; 32: 151–158

Geduldig ET, and Kellner CH: Electroconvulsive therapy in the elderly: new findings in geriatric depression. Curr Psychiatry Rep 2016; 18:40

Kellner CH et al: Right unilateral ultrabrief pulse ECT in geriatric depression: Phase 1 of the PRIDE study. Am J Psychiatry 2016; 173:1101-1109

Kellner CH et al: A novel strategy for continuation ECT in geriatric depression: Phase 2 of the PRIDE study. Am J Psychiatry 2016; 173: 1110-1118

Kirov GG et al: Evaluation of cumulative cognitive deficits from electroconvulsive therapy. Br J Psychiatry 2016; 208: 266-270

Kumar S et al: Systematic review of cognitive effects of electroconvulsive therapy in late-life depression. Am J Geriatr Psychiatry 2016; 24: 547-565

Mohn C, and Rund BR: Significantly improved neurocognitive function in major depressive disorder 6 weeks after ECT. J Affect Disord 2016; 202: 10-15

Zhong X et al: Mood and neuropsychological effects of different doses of ketamine in electroconvulsive therapy for treatment-resistant depression. J Affect Disord 2016; 201: 124-130

IMPLICATIONS OF EFFECTIVE DIFFERENTIAL DIAGNOSIS

Clarissa Giebel
Senior Postdoctoral Research Associate, School of Health Sciences, University of East Anglia

Dementia can present itself in many forms – ranging from the most common form of Alzheimer's disease to subtypes of vascular dementia, dementia with Lewy Bodies, Parkinson's disease dementia, or behavioural variant fronto-temporal dementia, to name but a few. Each subtype comes with a different set of more pronounced symptoms. Take a recent study by Moheb and colleagues (2017) for example, who have compared everyday functioning across three fronto-temporal dementia subtypes. The authors showed that people with bvFTD were more impaired than people with semantic or non-fluent variant primary progressive aphasias on bills, shopping, using the stove, and meals, amongst other tasks. In another study, Giebel and colleagues (2016) reported that people with vascular dementia showed higher levels of dependence on daily tasks, such as preparing a cold meal and following familiar routes, compared to people with Alzheimer's disease, both when initiating and performing the activities. But differences in everyday functioning profiles are not the sole characteristics of different dementia subtypes.

Cognition is another symptom that is affected differently across dementia subtypes. One example of a specific cognitive domain that varies across subtypes is executive functioning. People with fronto-temporal dementia perform worse on tasks involving executive function, compared to people with a diagnosis of Alzheimer's disease or semantic dementia (Kramer et al., 2003). As part of cognition, deficits with language can also be used to characterize the type of dementia. People with semantic dementia, as the name says, struggle with naming objects and communicating more and more as the condition progresses. In contrast, people with Alzheimer's disease will have more intact semantics.

One further symptom that can help distinguish different dementia subtypes from one another is behavioral problems. Signs such as lack of emotional response and social avoidance are more pronounced in apathetic and disinhibited forms of FTD compared to semantic dementia (Snowden et al., 2001). Recently, a study in South Korea also reported more pronounced behavioral and neuropsychiatric disturbances in bvFTD compared to PNFA (Park et al., 2017).

Whilst all these symptom profiles can aid in the differential diagnosis of dementia, employing neuroimaging to assess the regions of atrophy in the brain are also employed in this diagnosis process. However, only post-mortem examination can provide the most precise form of differential diagnosis. So what are the benefits of a differential diagnosis?

On the one hand, receiving a specific dementia diagnosis can help in selecting the most suitable type of medication. However, considering the lack of medication that can stop the dementia overall, it is equally important to consider the effects of a differential diagnosis on the care management and treatment plan of the person with the diagnosis.

Once a diagnosis is received, care management should be put in place, considering the strengths and limitations of the person with dementia. This can be illustrated by the example of differential behavioral profiles. People with a diagnosis of bvFTD experience more severe behavioral problems, such as apathy and changes in eating behavior, compared to people with PPA-sv. Thus, post-diagnosis, treatment plans should be put into place, on top of any medication, that would help train the carer, if indeed available, in better managing those behavioral problems in people with bvFTD, and potentially adapt the home environment – a frequent source of behavioral problems in dementia. These particular non-pharmacological, or, as recently argued by eminent senior researchers in our field, ecopsychosocial (Zeisel et al., 2016) treatments would be more suitable to those receiving a diagnosis of bvFTD, than those with a diagnosis of AD.

Care management should also be adapted to the everyday functioning profiles of different diagnoses. Similar to behavioral problems, bvFTD is shown to impair function to a greater extent than AD or other fronto-temporal dementia subtypes, such as the semantic variant of primary progressive aphasia (PPA-sv), in tasks such as meal preparation and

IMPLICATIONS OF EFFECTIVE DIFFERENTIAL DIAGNOSIS, *continued on next page*

IMPLICATIONS OF EFFECTIVE DIFFERENTIAL DIAGNOSIS, *continued from page 12*

shopping. This suggests that people with bvFTD require more treatment from occupational therapists in helping them perform those activities independently for as long as possible. Equally, if we know the trajectory of independence decline for different subtypes, which we do for some, care management can place importance on specific activities for different subtypes, to ensure that people, no matter whether they have vascular or Lewy Body dementia, can stay independent for as long as possible.

These major variations in symptom profiles between different dementia subtypes indicate a potential pathway to better adapt care management plans to the individual needs of patients. Of course, much more needs to be done still to completely understand the different symptomatologies of dementia subtypes, but the existing evidence could help in shaping care management more effectively to target the problem areas most pronounced in each subtype.

References

Giebel, C.M., Burns, A., & Challis, D. (2016). Taking a positive spin: preserved initiative and performance of everyday activities across mild Alzheimer's, vascular and mixed dementia. International Journal of Geriatric Psychiatry, doi: 10.1002/gps.4553.

Kramer, J.H., Jurik, J., Sha, S., Rankin, K., Rosen, H., Johnson, J., & Miller, B. (2003). Distinctive Neuropsychological Patterns in Frontotemporal Dementia, Semantic Dementia, and Alzheimer Disease. Cognitive & Behavioral Neurology, 16(4), 211-218.

Moheb, N., Mendez, M.F., Kremen, S.A., & Teng, E. (2017). Executive Dysfunction and behavioral symptoms are associated with deficits in instrumental activities of daily living in frontotemporal dementia. Dementia and Geriatric Cognitive Disorders, 43(1-2), 89-99.

Park, M.H., et al. (2017). Behavioural and neuropsychiatric disturbance in three clinical subtypes of frontotemporal dementia: a clinical research center for dementia of South Korea-FTD Study. Australasian Journal on Aging, 36(1), 46-51.

Snowden, J.S., Bathgate, D., Varma, A., Blackshaw, A., Gibbons, Z.C., & Neary, D. (2001). Distinct behavioural profiles in frontotemporal dementia and semantic dementia. Journal of Neurology, Neurosurgery & Psychiatry, 70(3), 323-332.

Zeisel, J., Reisberg, B., Whitehouse, P., Woods, R., & Verheul, A. (2016). Ecopsychosocial Interventions in Cognitive Decline and Dementia – A New Terminology and a New Paradigm. American Journal of Alzheimer's Disease & Other Dementias, 31(6), 502-507.

HEALTH PROMOTION INTERVENTION FOR ELDERLY AND MENTAL HEALTH ?

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Good mental health can assure active participation of elderly in society. It may also contribute to better physical health and well-being. Health promotion interventions can contribute to maintaining good health among the elderly. Within the project "PRO HEALTH 65+Health Promotion and Prevention of Risk – Action for Seniors" we have examined two community-based interventions. Both interventions can be classified as complex – they do not aim to target particularly mental health problems, but rather to improve the whole well-being of elderly.

The first intervention is known as physical activity on prescription (PARS). The main goal of this intervention is to increase physical activity and to provide better access to leisure facilities. The intervention has been applied in many European countries (Belgium, Denmark, Germany, the Netherlands, Sweden, Portugal and UK), as well as in Australia, US, Canada and New Zealand. Some studies conducted in UK have shown that PARS can have positive effect on decreasing depression among elderly. We have performed a systematic literature review with meta-analysis in order to explore to what extent (i) PARS is effective among different diagnostic groups and (ii) the design characteristics of this intervention can influence the effectiveness of intervention for different diagnosis groups. The intervention is tailor-made, and each individual gets specific advice from a health professional. Furthermore, PARS are prescribed by GPs who also follow up on the progress. Our results show that the effectiveness of PARS among elderly with depression depends on the design of the intervention; when people with similar socio-demographic characteristics are included, the intervention is more effective. However, meta-analysis where we have included depression as a diagnostic category did not support the effectiveness of PARS for this diagnostic category. Detailed information can be found in:

Arsenijevic, J. & Groot, W. (2017). Physical activity on prescription schemes (PARS): do programme characteristics influence effectiveness? Results of a systematic review and meta-analyses. BMJ open, 7(2), e012156.

Arsenijevic, J. & Groot, W (2017). Physical activity on prescription - moving slowly towards healthy ageing. http://www.pro-health65plus.eu/userfiles/downloads/policybriefs/PRO-Health%2065+%20Policy%20brief%206.pdf

We have also examined the effectiveness of another community-based health promotion intervention that has existed in the Netherlands since the 1960's. This intervention is known as "household help" – help by professionals not only to clean the house but also to observe the mental health of clients. Many elderly in the Netherlands have perceived this type of help as a way of socialization – they can have a coffee and discuss daily life with the professional helper. In this way, the intervention has also had a role in preventing loneliness among elderly. In 2007, household help policy changed as part of a broader health care reform, i.e. the introduction of the Wmo (Wet maatschappelijke ondersteuning). The main changes were a switch from premium-based financing to tax-based financing, a change in eligibility requirements, and a greater call on volunteers and informal care providers to deliver household help. (Informal care providers are usually family members, rather than professionals who are trained and educated to monitor the physical and mental health of the elderly.) In the context of Wmo, hours of formal help

HEALTH PROMOTION INTERVENTION FOR ELDERLY AND MENTAL HEALTH, *continued on next page*

HEALTH PROMOTION INTERVENTION FOR ELDERLY AND MENTAL HEALTH, *continued from page 14*

decreased, and consequently, formal help could only provide cleaning, with less or no time for coffee and discussions of daily life issues.

In our study, we have examined if those changes in policy have had negative effects on loneliness among elderly in the Netherlands. We have used observational longitudinal data provided by the Survey of Health, Ageing and Retirement in Europe (SHARE). We have compared the level of loneliness among elderly in the Netherlands with that among elderly in other European countries (Austria, Germany, Sweden, Spain, Italy, France, Denmark, Switzerland and Belgium), before and after the policy changes. We have analyzed the data using a difference-in-differences (DiD) estimator that allows us to estimate the effects of the policy changes using individual-level data. We have also applied the synthetic control method (SCM) to combine observational data with causal interference analyses, providing policy effect estimations with high external validity. The results from our statistical analyses, using both DiD and SCM, are consistent. They show that loneliness among older adults in the Netherlands has increased since 2011, but is still lower than in other European countries (such as those in southern Europe). Furthermore, our results show that those changes cannot be attributed to the policy changes. This increase in loneliness among elderly in Europe might be related to the fact that elderly are more willing to acknowledge loneliness now than in the past.

GROWING NEED FOR GERIATRIC FORENSIC EVALUATIONS

Karen Reimers, MD, FRCPC

As the global population ages, we are seeing a growing need for geriatric forensic evaluations. Increasing rates of dementia and other neurocognitive disorders in the aging population complicate the evaluation and treatment of a growing number of individuals. We are simultaneously facing a critical shortage of medical and mental health professionals with specialized expertise in geriatric forensic evaluations.

Stakes are often high for geriatric forensic evaluees. A finding of incapacity can strip an individual of his or her individual rights.

Clinicians working with elderly patients are frequently asked to evaluate capacity and other medicolegal questions. A recent article by Doron et al. in *International Psychogeriatrics* gives us a fascinating glimpse into the wide range of legal issues where dementia is relevant: legal questions that go far beyond capacity and guardianship issues.

Questions for geriatric forensic evaluators	
Decision making capacity	Driving
Guardianship	Consent to research
Financial capacity	Criminal, competency to stand trial
Contracts	Sexual issues in nursing home
Testamentary capacity, undue influence	Elder abuse

Will contests are increasing in common law jurisdictions around the world. We will soon be facing an unprecedented transfer of personal wealth amassed by the baby boomer generation. Assessment for testamentary capacity and vulnerability to undue influence can be complex. It often requires retrospective evaluation of a deceased testator. For allegations of undue influence, there is active debate within the field about whether psychiatrists should attempt to answer the ultimate legal question.

Many tools and instruments have been proposed to assist clinicians with geriatric forensic evaluations. These include specialized instruments for medical decision making and for

GROWING NEED FOR GERIATRIC FORENSIC EVALUATIONS, *continued on next page*

GROWING NEED FOR GERIATRIC FORENSIC EVALUATIONS, *continued from page 15*

financial capacity assessment. Such tools can potentially be helpful; however, none are currently in widespread use.

Based on my own research, the table below offers some highlights for general assessment techniques, pitfalls and best practices for forensic evaluations in the elderly:

Best Practices for Geriatric Forensic Evaluations
1. Identify the legal issue and any relevant legal standards
2. Presume competence until proven otherwise
3. Consider multiple hypotheses in every case
4. Review the medical record and other relevant documents
5. Avoid overreliance on family report and/or unverified information
6. Conduct a comprehensive clinical interview and mental status examination
7. Beware of overdiagnosing Alzheimer's disease
8. Know local reporting rules regarding safety and liability
9. Offer opinions only if supported by data
10. Avoid making long range projections

I would like to recommend two freely available resources I discovered in my research on geriatric forensic evaluations in the US. Both were produced with an American audience in mind, but they address universal issues facing clinicians caring for geriatric patients in primary care and mental health settings around the world. These resources offer valuable practical guidance for clinical assessment. They can be downloaded free online.

Helpful resources for the practicing psychiatrist	
	**Assessment of older adults with diminished capacity: a handbook for psychologists (2008)** American Bar Association and American Psychological Association Available online at https://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf
	**Clinician's guide to assessing and counseling older drivers, 3rd edition (2016)** American Geriatrics Society and National Highway Traffic Safety Association Available online at https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/812228_cliniciansguidetoolderdrivers.pdf

As practicing clinicians caring for elderly patients, we are frequently faced with capacity and other medicolegal questions. I hope you will join me in working to improve forensic evaluations in the elderly. Though geriatric forensic evaluations are often challenging, it can be interpersonally meaningful and professionally rewarding for clinicians to implement competent skills in this area.

References

Doron, I. I., P. Werner, B. Spanier and O. Lazar (2017). "The legal appearances of dementia in court rulings: mapping the terrain." International Psychogeriatrics: 1-9.

Lichtenberg, P. A. (2016). "Financial exploitation, financial capacity, and Alzheimer's disease." American Psychologist 71(4): 312.

Gutheil, T. G. (2014). "The Practical Assessment of Testamentary Capacity and Undue Influence in the Elderly." Journal of the American Academy of Psychiatry and the Law 42(2): 268.

Peisah, C., S. Finkel, K. Shulman, P. Melding, J. Luxenberg, J. Heinik, R. Jacoby, B. Reisberg, G. Stoppe, A. Barker, H. Firmino and H. Bennett (2009). "The wills of older people: risk factors for undue influence." Int Psychogeriatr 21(1): 7-15.

Plotkin, D. A., J. E. Spar and H. L. Horwitz (2016). "Assessing Undue Influence." J Am Acad Psychiatry Law 44(3): 344-351.

IPA AFFILIATE EVENTS

Korean Association for Geriatric Psychiatry (KAGP)
Diagnosis and Treatment of Alzheimer's A to Z
8 July 2017
Busan, Korea
http://kagp.or.kr

Alzheimer Latin America (AIB)
Latin American Congress on Alzheimer's
18-21 October 2017
Santo Domingo, Dominican Republic
http://www.congresoaib2017.com/

Canadian Academy of Geriatric Psychiatry (CAGP)
37th Annual Scientific Conference
4-5 November 2017
Toronto, Canada
http://www.cagp.ca

Faculty of Psychiatry of Old Age Conference 2017
Capacity, Creativity and Ageing in Clinical Practice
8-10 November 2017
Queenstown, New Zealand

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MEETINGDEM; IMPLEMENTATION AND VALIDATION OF THE MEETING CENTRES SUPPORT PROGRAMME IN EUROPE

Rose-Marie Dröes, PhD, on behalf of the MEETINGDEM Consortium
Professor of Psychosocial Care for People with Dementia, Department of Psychiatry, VU University Medical Center, Amsterdam; Project Coordinator of MEETINGDEM

During the last three years, an interesting and successful project in dementia care, called MEETINGDEM, has been implemented in several countries in Europe, funded by the Joint Programme Neurodegenerative Diseases research. MEETINGDEM (2014-2017) aims to adaptively implement, evaluate and disseminate the evidence based Meeting Centers Support Programme (MCSP) for people with dementia and their carers in Europe. MCSP consists of a social club for people with dementia, where they can participate in recreational and creative activities, as well as in therapeutic interventions, three days per week; informative meetings and discussion groups for their family caregivers, in addition to a weekly consultation hour, monthly center meetings and social activities with their loved ones, are offered in socially integrated community centers.

The programme is theoretically based on the Adaptation-Coping model (Dröes et al, 2011) and aims to support people with dementia and their caregivers in dealing with the consequences of dementia. As such the MCSP model is particularly useful in frameing post-diagnostic support (Brooker et al, 2017).

MCSP was originally developed in the The Netherlands (Dröes et al, 2000, 2003, 2004a,b) and is now being implemented in other European countries, such as Italy, Poland, the UK and recently also in Spain. The consortium partners of MEETINGDEM are VU University medical centre in Amsterdam (The Netherlands), University of Bologna (Italy), Fondazione Don Gnocchi Onlus in Milan (Italy), Wroclaw Medical University (Poland), University of Worcester (UK) and University College London (UK). They succeeded to successfully prepare and adaptively implement, together with local care, welfare and volunteer organisations who participated in the initiative groups, 13 Meeting Centres in these countries. The implementations were accompanied by research evaluating the implementation process (Mangiaracina et al, 2017), culture specific adaptations, the effectiveness, cost effectiveness and user experience. Results of the project are expected to be published late 2017.

People who are interested in updates on this project or in setting up Meeting Centres in their own country or region, are advised to sign up for the free project newsletter at the MEETINGDEM website (www.meetingdem.eu) or to contact the researchers via meetingdem.eu@gmail.com

MEETINGDEM; IMPLEMENTATION AND VALIDATION OF THE MEETING CENTRES SUPPORT PROGRAMME IN EUROPE, *continued on next page*

MEETINGDEM; IMPLEMENTATION AND VALIDATION OF THE MEETING CENTRES SUPPORT PROGRAMME IN EUROPE, *continued from page 17*

Below a link with more information and a movie on this project.

http://www.neurodegenerationresearch.eu/2016/10/meetingdem-progress-update-how-one-jpnd-project-is-bringing-a-tried-and-tested-dutch-model-for-dementia-care-to-italy-poland-and-the-uk/

References

Brooker, D., Evans, S.B., Dröes, R.M. (2017) Framing outcomes of post-diagnostic psychosocial interventions in dementia. Working with Older People, 21 1,13-21

Dröes, R.M., Breebaart, E., Tilburg, W. van, and G.J. Mellenbergh The effect of integrated family support versus day care only on behavior and mood of patients with dementia. International Psychogeriatrics, 2000, 12(1): 99-116.

Dröes, R.M., Meiland, F.J.M., Lange, J. de, Vernooij-Dassen, Tilburg, W. van The meeting centres support programme; an effective way of supporting people with dementia who live at home and their carers. Dementia. The International Journal of Social Research and Practice, 2003, 2(3):421-438.

Dröes, R.M., Breebaart, E., Meiland, F.J.M., Tilburg, W. van, Mellenbergh, G.J. Effect of Meeting Centres Support Programme on feeling of competence of family caregivers and delay of institutionalization of people with dementia. Aging & Mental Health, May 2004a, 8(3): 201-211.

Dröes, R.M., Meiland, F.J.M., Schmitz, M., Tilburg, W. van Effect of combined support for people with dementia and carers versus regular day care on behaviour and mood of persons with dementia: results from a multi-centre implementation study. International Journal of Geriatric Psychiatry, 2004b,19: 673-84

Dröes, R.M., Van Mierlo, L.D., Meiland, F.J.M., Van der Roest, H.G. Memory problems in dementia: Adaptation and copingstrategies, and psychosocial treatments. Expert Reviews Neurotherapeutics, 2011,11(12)1769-1782.

Mangiaracina, F. et al. Not Re-inventing the Wheel: The Adaptive implementation of the Meeting Centres Support Programme in four European countries. Aging and mental Health, 2017, 21(1):40-48.

AN UPDATE FROM ALZHEIMER'S DISEASE INTERNATIONAL: FOCUS ON "DEMENTIA-FRIENDLY COMMUNITIES"

Jennifer Tu, Assistant to the IPA Bulletin *Editor-in-Chief*

The 32nd International Conference of Alzheimer's Disease International (ADI) took place in Kyoto on April 26-29, drawing over 3,000 delegates, including people with dementia and their families, community advocates, researchers, clinicians, and other professionals, participating in more than 200 presentations and 400 poster presentations on the most recent insights and progress in dementia care and research.

Amidst the plenary sessions, symposia, and keynote addresses, one main theme was particularly noticeable this year: the '**nothing about us without us**' movement. People with dementia (PwD) played a significant part in the conference. These courageous individuals emphasized the crucial role of social connections and support — in the words of one PwD, "*it's not important what we achieve as individuals, but it's what we achieve as a community*." Dementia-friendly communities were a main theme of this year's conference, with both a pre-conference symposium, "Building a dementia-friendly world," and plenary session, "Dementia friendly communities," devoted to the subject.

What are "dementia-friendly communities"?

In short, dementia-friendly communities promote feelings of inclusion and social support for PwD, empowering PwD and recognizing their contributions, challenging stigma, enabling personalized integrated care, educating the public to befriend and help PwD, and advocating for provision of appropriate transport and physical environments.

Here, I would like to summarize the types of initiatives highlighted at the conference, give an example of each, and provide key takeaways.

AN UPDATE FROM ALZHEIMER'S DISEASE INTERNATIONAL: FOCUS ON "DEMENTIA-FRIENDLY COMMUNITIES", *continued on next page*

AN UPDATE FROM ALZHEIMER'S DISEASE INTERNATIONAL: FOCUS ON "DEMENTIA-FRIENDLY COMMUNITIES", *continued from page 18*

Examples of dementia-friendly initiatives

"Dementia cafés." As a common model across countries, the dementia café is an open space for PwD, their family and caregivers, and the general public to freely interact, providing a space for relationship-building between PwD and their carers or peers, as well as de-stigmatizing dementia through personal contact between citizens and those whom they may not normally meet.

- In Argentina, "Café con A.L.M.A" takes place in Buenos Aires on a regular basis. Doctors are also involved as musicians and participants, educating and encouraging participants to be 'multipliers' of awareness and action in the community.

Educational programs. Initiatives to involve children, 'the parents of the future', have been implemented across high-, middle-, and income- countries.

- The Iran Alzheimer's Association's Education Project developed and distributed brochures to 4500 5th graders, with quick and easy feedback due to collaboration with Education Board

Awareness through media. In addition to structured educational programs, arts and media have been used in countries across the world to raise awareness among the general public.

- In the Netherlands, online and offline training courses are available for workplaces, public servants, and the general public, teaching about skills for personal contact with PwD in the community. This program was boosted by a PR-stunt of hidden camera video, revealing the actual reactions of people when encountering an actor posing as a PwD in streets. One passerby reflected on her experience: "if you know what's going on you're more inclined to help." This stunt yielded 2 million Facebook views, free publicity (in newspapers, TV, and radio), awareness (indicated by online shares, comments, stories), and 3000 registrations in the training program, in just a few days.

Community watches. To meet the immediate need of disoriented PwD who are "night wandering," many countries have tapped into civil society, at the intersection of bottom-up and town-down approaches.

- In Indonesia, a "'purple squad" of volunteers has been training government workers and 'rescuing' wandering PwD. There is work in progress on adding a 'missing elderly' button to an existing app that allows citizens to report problems to the government.

Employment and cultural preservation. For people with milder stages of dementia, employment provides many physical, mental, and social benefits. Elderly PwD are also valuable sources of cultural wisdom and experience, and mutually beneficial exchanges with societies across the world can and should be tapped into.

- As part of Japan's "Orange Road" dementia plan, elderly women, who have been found to maintain procedural memory and perform well in tea leaf picking, have been recruited for this work of great cultural value.

Keys to success

From these examples of dementia-friendly initiatives, as well as further speeches from policy experts from the World Health Organization (WHO) and local Alzheimer's associations, several crucial points stood out:

"A community engagement theory of change." Dementia-friendly communities are dependent on a group of active, compassionate members. The WHO is currently developing a framework which organizes dementia-friendly initiatives by the "3 P's": people, places, and partnerships. The input of resources, actions and interventions, measurable results, and long-term goals of such initiatives must take place within these three sectors of community.

Care homes and other spaces as community centers. Dementia-friendly communities may break down the black-and-white boundaries between institutionalization and community-living, allowing PwD and the general public to interact freely.

AN UPDATE FROM ALZHEIMER'S DISEASE INTERNATIONAL: FOCUS ON "DEMENTIA-FRIENDLY COMMUNITIES", *continued on next page*

AN UPDATE FROM ALZHEIMER'S DISEASE INTERNATIONAL: FOCUS ON "DEMENTIA-FRIENDLY COMMUNITIES", *continued from page 19*

In regions where assisted living facilities and care homes have not yet been established, outreach can be done directly in community spaces. "Begin where the people are already, and equip them to live their normal lives," advised one speaker, when asked how dementia-friendly initiatives should start in lower- and middle-income countries. For instance, in the UK, black and minority ethnic communities are underrepresented in dementia services; in response, the Alzheimer's Society began a monthly "dementia cafe" at the East London Mosque for the area's Bengali community, and it now draws over 200 people with dementia, their families and carers.

Inclusivity and rights-based action. The process of building dementia-friendly communities should be rights-based and completely inclusive of PwD of all backgrounds and identities. In the words of one speaker with mixed dementia, "We can become a co-researcher, we can be part of a team. But to do so, we need to be educated, not just trained. Then there won't be any fear, myth, or misunderstandings." Dementia-friendly initiatives should include PwD of all cultures, sexualities, and stages of disease.

Public relations and multi-channel media. Reaching the general public is necessary for increasing awareness and access to help for PwD and caregivers. This has enabled the success of many dementia-friendly initiatives, and requires the engagement of skilled people, such as youth with energy, creativity, and experience with social media.

Cross-sector buy-in. People with expertise across transport, finance, retailer/business, public service, arts, technology, and other fields are needed to make dementia-friendly communities possible. The government should support initiatives (example: the Prime Minister's Champion Group in the UK). Grassroots projects should be allied with local, regional, and national infrastructure (example: "codes of practice," by which organizations or businesses meet "dementia-friendly criteria," are approved by a governing body, achieve a "dementia-friendly symbol," and complete an annual self-assessment).

Further resources

(Alzheimer's Society British Columbia)
Dementia-Friendly Community "Train the Trainer" program
Dementia-Friendly Community Local Government Toolkit

(WHO Thematic brief)
"Ensuring a human-rights based approach for people with dementia"

(WHO Guide to using core indicators)
"Measuring the age-friendliness of cities"

WHO Kobe Center:
http://www.who.int/mental_health/neurology/dementia/en/
http://www.who.int/kobe_centre/en/
http://www.who.int/kobe_centre/ageing/age_friendly_cities/en/

Alzheimer' Society:
https://www.alzheimers.org.uk/

Building A Dementia Friendly World Symposium
Watch the event: http://tinyurl.com/Kyotosymposium
Case studies booklet: http://tinyurl.com/dfcasestudies

Alzheimer's Disease International (ADI)
https://www.alz.co.uk/

AIP NATIONAL CONGRESS
AIP (ITALIAN PSYCHOGERIATRIC ASSOCIATION) 17TH NATIONAL CONGRESS, 29 MARCH -1 APRIL 2017, FLORENCE, ITALY

Laura Valzolgher
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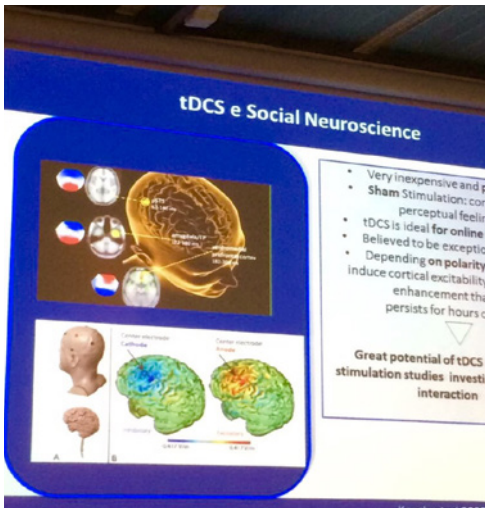
AIP, the Italian Psychogeriatric Association, is an affiliated IPA Organization. Since 1989, AIP has been working to promote geriatric mental health education in Italy, through its 17 National Congresses, multidisciplinary components, and strong international connections.

The 17th AIP National Congress was held in Florence from March 29th to April 1st 2017. There was large participation not only by doctors of different disciplines (geriatricians, neurologists, psychiatrists) but also by different health care professionals (psychologists, nurses, physiotherapists, speech therapists and educational therapists) from all over the country.

The title of the event this year was "Psychogeriatric: clinical practice, research, hopes". This definition reflects the AIP's vision of the central role of clinical practice, great attention to scientific progress, and a positive approach to the health problems of the elderly. "Hopes" refer to the daily clinical efforts of health professionals and the scientific work of researchers that will give future answers to geriatric mental health problems. Hope, as President Marco Trabucchi pointed out, is conviction in the worth of what we do everyday; without hope, we would be "alone and lonely".

A neuropsychological course on degenerative disease, as well as different pre-conference symposia for health care professionals, were held before the congress opening. There was greater participation of non-medical professionals than ever before, which reflects their growing importance in the treatment of geriatric health problems. The Congress was introduced by a round table about the difficult "art of aging", in which both individual choices and social factors might play a role. Afterwards, there were some very interesting symposia and lectures focused on chronicity and chronic diseases: dementia, depression, Parkinson disease, and sleep disturbances. These are all crucial concerns in contemporary medicine. Claudio Vampini and Amalia Bruni faced the topic of Depression and Therapy in the elderly. Carlo Caltagirone talked about Neuroinflammation, while Alessandro Padovani held a symposium on New Treatments

AIP NATIONAL CONGRESS AIP (ITALIAN PSYCHOGERIATRIC ASSOCIATION) 17TH NATIONAL CONGRESS, 29 MARCH -1 APRIL 2017, *continued on next page*

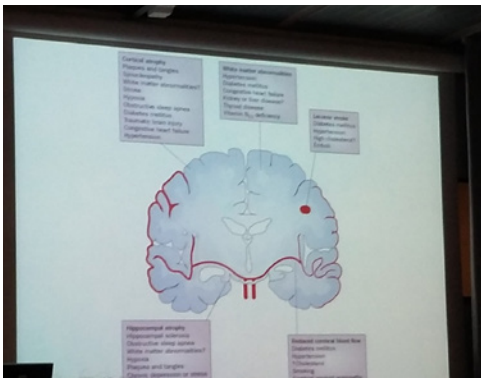


AIP NATIONAL CONGRESS AIP (ITALIAN PSYCHOGERIATRIC ASSOCIATION) 17TH NATIONAL CONGRESS, 29 MARCH -1 APRIL 2017, *continued from page 21*

for Alzheimer's Dementia. Symposia on specific topics, such as pain and suicide in the geriatric population, were also successful. Giuseppe Bellelli presented the results of Delirium Day (a national study on the prevalence of Delirium in the hospital setting and residences). Colleagues of the Memory Clinic of Bolzano presented original work about the Evaluation of the Caregiver Burden in Dementia in the Oral Communications component of the congress.

Members of the Directory Board were also elected during the congress. President for the next three years is Marco Trabucchi; Vices are: Diego De Leo (for the psychiatric component), Alessandro Padovani (for the neurologic component), Nicola Ferrara (for the geriatric component) and Giovanna Ferrandes (for the Psychologists). Angelo Bianchetti was confirmed as secretary, and Luigi Ferrarini was elected head of the Institution of Guarantee (introduced after the revision of the Statute).

The 17th National congress concluded on Saturday April 1st, with great satisfaction from the organizing committee and the participants.



REGISTRATION FOR THE 2017 ONLINE COURSE IS NOW OPEN!

This year the course will be a 3-month crash course co-chaired by Dr. Mark Rapoport, Dr. Dallas Seitz, president of the CAGP, and Dr. Andrew Wiens. Faculty members include Dr. Tarek Rajji, Dr. Beniot Mulsant, Dr. Marnin Heisel, Dr. Maria Hussain, Dr. Ken Shulman, Dr. Laura Gage, Dr. Keri-Leigh Cassidy, Dr. Peter Chan, Dr. Simon Davies, Dr. Carl Cohen, Dr. Charles Reynolds III, Dr. Eric Lenze, and Dr. Michael Reinhardt.

The review course was developed with the technical and educational guidance of Dr. Marcus Law, Director of Technology Enabled Learning at the Centre for Faculty Development of the University of Toronto.

This Geriatric Psychiatry Online course will consolidate learning of geriatric psychiatry in an innovative, interactive, and fun manner. Our program is geared to physicians, health care professionals and residents who are interested in up-to-date learning about the psychiatric care of the elderly, and features interactive asynchronous online learning (sign on at your convenience). This 3-month course, comprised of 13 one-week modules, is led by expert faculty and covers a wide array of topics in geriatric psychiatry at an advanced level.

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