IPA Bulletin

INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION • BETTER MENTAL HEALTH FOR OLDER PEOPLE

VOLUME 39, NO. 2 • JUNE 2022

WHAT'S INSIDE

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PRESIDENT'S MESSAGE – MANABU IKEDA

Dear Colleagues,

In many parts of the world, including in my home country of Japan, there are still many challenges related to both new variants of COVID-19 and the war in Ukraine. While we were working towards hosting our 2022 Congress in Lisbon, Portugal, the Board of Directors made the difficult decision to postpone until 2023. We hope to have new dates to announce soon.

In the interim, our planning task force is looking to new, alternative ways to engage early career professionals and promote the field of older-adult mental health. For the second year, IPA will raise awareness with Older Adult Mental Health Awareness Week taking place from October 1-10, 2022. We encourage you to learn more and share this global initiative with your colleagues, local networks and professional organizations. If you are interested in hosting a regional, virtual program as part of this initiative, or would like more information, please reach out to the Task Force via email.

Since our last Bulletin, the IPA Committees have been hard at work presenting a virtual program by the Early Career Network (ECN) entitled Methodological Challenges in Research for Early Career Professionals. In addition, the Webinar Committee produced a highly rated program: An Update on Interventions for Behavioral and Psychological Symptoms of Dementia. Finally, the Journal Club held their fourth program with a presentation on the paper "Neuropsychiatric symptoms and comorbidity: Associations with dementia progression rate in a memory clinic cohort." Both the ECN program and the Journal Club included robust discussion amongst attendees, encouraging collegial exchange. All programs were recorded which members can access through the IPA Online Learning Portal (login is required for the Journal Club).

If you are, or work with, an early career researcher or clinician in any field of older adult mental health, I invite you to apply to become an Early Career Network (ECN) member. The ECN is open to those with less than five years of experience in the field of older adult mental health and offers nine months of free IPA membership. Applications can be completed on the IPA website.

PRESIDENT'S MESSAGE, *continued on page 3*

EDITOR'S NOTE – TZUNG-JENG HWANG

Although the COVID-19 pandemic seems to ease its impact in many countries, the world is still not stable, especially after the outbreak of the Russia-Ukraine war. We hope you and your family are well. Because of many uncertain factors, the IPA Board of Directors decided to postpone the in-person Congress to 2023, and provide a virtual program in October in conjunction with the Older Adult Mental Health Awareness Week. Many web-based activities will be continued through our IPA website. Please take these opportunities to connect with IPA friends and members.

I want to thank Drs. Jorge Cuevas and Migita D'cruz for their devotion to the IPA Bulletin in the past two years. Dr. Javier Vicente-Alba (Spain) and Dr. Debanjan Banerjee (India) will take the vacant posts as assistant editors. We warmly welcome them on board and look forward to their contribution.

In the "***International Psychogeriatrics* Review Column**", Ms. Qiyini Ma et al. review the paper "Dementia knowledge and associated factors among older Chinese adults: a cross-national comparison between Melbourne and Beijing" by Mei Zhao et al. The review shows that there were similar levels of overall dementia knowledge between older Chinese adults in Melbourne and Beijing. But the associated factors related to dementia knowledge vary between the two groups. The study concluded that dementia education programs should focus on caregiving information and risk factors for dementia.

There are four articles in "**Research and Practice**", and two in "**Around the World**". In "**Research and Practice**", Dr. André Stang (Germany) et al. discuss PISTA (*Processing Inner Strength Toward Actualization)* as a sound-based intervention to assist older adults with psychosocial distress. Some evidence shows that PISTA may be beneficial for reducing behavioral and psychological symptoms of dementia. Nour Awad and Dr. Rita Khoury (Lebanon) review the issue of suicide in older adults, including risk factors and preventive strategies. One simple and potentially useful screening tool (The SLU "AMSAD") is also introduced. Dr. Javier Vicente-Alba (Spain) reports a higher suicide rate in older Spanish adults during the COVID-19 pandemic in 2020, especially among those above 80 (20% increase compared to 2019). Dr. Laura Valzolgher (Italy) updates us on the Wernicke-Korsakoff syndrome, a less frequent but preventable form of cognitive disorder. The syndrome is often caused by thiamine (vitamin B1) deficiency due to malnutrition in chronic alcohol consumption and other less recognized conditions such as cancer, chronic inflammatory disease, and anorexia nervosa. Replacement must be early and adequate with a high dosage of parenteral thiamine to prevent the progression of brain damage and reverse symptoms.

EDITOR'S NOTE, *continued on next page*

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There are two articles in "**Around the World**". Dr. Clarissa Giebel (UK) shares how her dementia research experiences evolved to setting up the Liverpool Dementia & Ageing Research Forum in 2019 and then developing "The Ageing Scientist podcast" one year ago. She also welcomes any IPA members to join the podcast as a panelist. Dr. Nahathai Wongpakaran et al. (Thailand) present their experiences of using telehealth to provide mental healthcare for long-term care residents during the COVID-19 pandemic in Thailand. Professionals from different disciplines also share their feelings and thoughts from these experiences.

Please submit articles and share your thoughts and experiences with us! You can reach us at IPABulletin@ipa-online.org.

PRESIDENT'S MESSAGE, *continued from cover*

IPA volunteers are the strength of our organization, and we appreciate the efforts of the working groups, committees, task forces and Board of Directors. If you are interested in connecting with peers from around the world, joining a committee or task force is an excellent place to start. These groups typically meet once per month via Zoom. I encourage you to learn more at the IPA website and reach out to the IPA Secretariat with questions or to volunteer.

With Kindest Regards,
Dr. Manabu Ikeda

DEBATE SERIES: "Is retirement the end of a productive life?"

WEDNESDAY, 22 JUNE 2022 • 7:00am CT/ Secretariat

See Local Time:

Watch the IPA Online Learning Portal for more information

The International Psychogeriatric Association (IPA) presents a new Debate Series beginning 22 February 2022 with the topic ***Is retirement the end of a productive life?***

This is a widespread and sometimes universal concept but... is it true…?

In this new edition of the IPA Debate Series, presenters, moderators and audience will discuss different opinions and perspectives, coming from distinct activities and cultures, in order to give an answer to such question and provide new references for this polemic issue.

The Debate is planned for 22 June at 07.00 Central Time, expecting 90 minutes long.

Moderated by Prof. Raimundo Mateos and Dr. Edgardo Reich.

22 June 2022

7:00-8:30am CT/ Secretariat [See local time]

CLICK HERE TO REGISTER

Presenter: Agostinho Almeida *(Porto, Portugal)*
Presenter: Ricardo Iacub *(Buenos Aires, Argentina)*
Presenter: Chiu Wa (Linda) Lam *(Hong Kong)*

Moderator: Raimundo Mateos, MD, PhD
IPA Debate Series- Program Organizer
Universidad de Santiago de Compostela
Spain

Moderator: Edgardo Reich, MD
IPA Debate Series- Program Organizer
Hospital Julo Mendez, Universidad de Buenos Aires
Argentina

REVIEW OF "DEMENTIA KNOWLEDGE AND ASSOCIATED FACTORS AMONG OLDER CHINESE ADULTS: A CROSS-NATIONAL COMPARISON BETWEEN MELBOURNE AND BEIJING" BY MEI ZHAO ET AL.

Qiyini Ma[1], Hong Mi[2], and Fei Sun[1]
[1]Michigan State University, Michigan, United States; [2]Zhejiang University, Hangzhou, China

Key highlights

- Older Chinese adults in Melbourne and their counterparts in Beijing reported similar levels of overall dementia knowledge. Similarities are also observed in dementia knowledge subdomains.
- Associates of dementia knowledge vary between the two groups: younger age and dementia worry were associated with higher levels of dementia knowledge in the Melbourne group, while family history of dementia was associated with higher levels of dementia knowledge in the Beijing group.
- Dementia education programs should focus on caregiving information and risk factors for dementia. Dementia beliefs and cultural values, as well as access to dementia education resources need to be examined in future studies.

Dementia is global health concern for individuals, communities and governments. Currently the number of people living with dementia worldwide is more than 55 million, and the number is projected to grow with an incidence of nearly 10 million new cases each year. It is estimated that the number of people with dementia will triple by 2050. To date, no cure is available for most types of dementia. Thus, being knowledgeable about dementia is important for individuals, so that they can take proactive approaches to prevent dementia onset.

Although considerable research has explored dementia knowledge and associated factors, migration status, which is an important sociocultural factor, was rarely included. It is reported in dementia research that immigrants might be vulnerable to cognitive impairment (Zhao *et al.,* 2021); however, there is little research that discusses differences in dementia knowledge levels between older adult, Chinese immigrants and their counterparts in China.

Zhao et al. conducted comparative research between Melbourne, Australia, and Beijing, China, from March to May 2019. The study aimed to compare dementia knowledge levels between these two groups, and inform the development of culturally and socially appropriate dementia education programs. A total of 379 older Chinese adults aged 50 or above, including 153 from Melbourne and 226 from Beijing, completed the survey in Zhao et al.'s study.

This study reported three major findings: first, there was not a significant difference in dementia knowledge between Chinese older adults living in Melbourne as compared to older adults living in Beijing. The Alzheimer's Disease Knowledge Scale (ADKS) was used to assess Alzheimer's disease knowledge, and the results showed that the average ADKS score was 17.2 ± 2.9 in the Melbourne group, which was almost identical to Beijing group (17.5 ± 2.9). The similarity was observed in the overall level of dementia knowledge between these two groups. According to the migrant process theory, immigrants tend to be highly educated, and engage in healthier behaviors as compared to counterparts living in their home country. One possible reason provided by the authors was related to sample selection. Given that participants were recruited from economically developed urban areas in both cities respectively, people share an equal opportunity to obtain dementia knowledge, especially those connected with

REVIEW OF "DEMENTIA KNOWLEDGE AND ASSOCIATED FACTORS AMONG OLDER CHINESE ADULTS, *continued on next page*

REVIEW OF "DEMENTIA KNOWLEDGE AND ASSOCIATED FACTORS AMONG OLDER CHINESE ADULTS, *continued from page 5*

community centers, which comprise a primary information source for them.

The second finding is the similarity across subdomains of dementia knowledge, including risk factors, assessment and diagnosis, symptoms, disease course, impact, caregiving, and treatment and management. Both groups had the greatest knowledge in the life impact subdomain, followed by the treatment and management subdomain. Risk factors and caregiving were the two subdomains which both groups had the least knowledge.

The third finding relates to differential factors associated with dementia knowledge between the two groups. It was found that younger age and self-rated dementia worry were significantly correlated with the ADKS total score in older Melbourne Chinese. A family history of dementia was the only variable associated with a greater level of dementia knowledge in Beijing group. In the absence of contact limitations, older Chinese in Beijing tended to have more connections with people living with dementia (PLWD) in their family; this is especially the case when older adults are caregivers for family members with dementia, which leads to them developing a greater knowledge of dementia. However, for those participants living in Melbourne, their own worry was associated with a higher awareness of dementia, and the presence of a family member with dementia appears to have no significant influence on dementia knowledge.

The projected increase in dementia incidence globally calls for more efforts to increase dementia awareness and knowledge. Previous studies indicate that immigrants might face unique obstacles, such as limited knowledge of the disease, social isolation and unfamiliarity of health care system due to language barriers. Yet, research on dementia knowledge in relation to immigrant status is limited. Hence, Zhao et al.'s study examining differences between immigrant and non-immigrant populations has significantly contributed to this area of research.

Public education programs designed to increase dementia knowledge among Chinese older adults are much needed. Dr. Zhao's findings affirmed the importance of public education, and highlighted specific domains, such as risk factors and caregiving as areas of emphasis for dementia education programs. Additionally, to effectively reach out to immigrant groups, culturally and socially appropriate approaches aligned with the older adults' beliefs and traditions should be used. Future studies need to include rural older adults, and examine disparities in access to dementia education, as well as health and social services, which can also affect older adults' dementia knowledge.

References:

1. *Kovaleva, M., Jones, A., Maxwell, C. A., & Long, E. M. (2021). Immigrants and dementia: Literature update. Geriatric nursing (New York, N.Y.), 42(5), 1218–1221. https://doi.org/10. 1016/j. gerinurse.2021.04.019*
2. *Zhao, M., Lv, X., Lin, X., You, E., Zhang, H., Ellis, K. A., ... & Lautenschlager, N. T. (2021). Dementia knowledge and associated factors among older Chinese adults: a cross-national comparison between Melbourne and Beijing. International Psychogeriatrics, 33(10), 1057-1067. doi:10.1017/S1041610221000053*
3. *Zheng, Y. B., Shi, L., Gong, Y. M., Wang, X. X., Lu, Q. D., Que, J. Y., Khan, M. Z., Bao, Y. P., & Lu, L. (2020). Public awareness and knowledge of factors associated with dementia in China. BMC public health, 20(1), 1567. https://doi.org/10.1186/s12889-020-09665-7*

Qiyini Ma is a PhD candidate at Zhejiang University (ZJU) and a visiting scholar of Michigan State University (MSU). Her research focus lies in population ageing and long-term care policy.

REVIEW OF "DEMENTIA KNOWLEDGE AND ASSOCIATED FACTORS AMONG OLDER CHINESE ADULTS, *continued on next page*

REVIEW OF "DEMENTIA KNOWLEDGE AND ASSOCIATED FACTORS AMONG OLDER CHINESE ADULTS, *continued from page 8*

Prof. Dr. Hong Mi works at the School of Public Affairs at Zhejiang University (ZJU) in China, and he serves as the Executive Director of Center for Non-Traditional Security & Peaceful Development Studies (NTS-PD), and Director of the Research Base for Population Big Data & Policy Simulation at ZJU. He has long been an expert consultant to China Ministry of Human Resource Management and Social Security Bureau. His research focuses on mathematical demography, social security (e.g. long-term care insurance, rural pension system), and data-mining analysis.

Dr. Fei Sun is a professor and coordinates the Levande Geriatric Social Work Certificate program at the School of Social Work (SSW) at Michigan State University (MSU). He is a fellow of The Gerontological Society of America, and has been working with the Department of Mental Health and Substance Abuse of World Health Organization (WHO) on developing a global toolkit for dementia friendly communities. His overall research area is aging and mental health with a focus on addressing the impact of Alzheimer's disease and related disorders in Chinese American community.

PISTA AS A SOUND-BASED THERAPEUTIC APPROACH TO HELP ADDRESS PSYCHOSOCIAL DISTRESS AMONG OLDER ADULTS

Andre Stang, Lana Chan, Fei Sun

Key highlights

- There are two perceptions of sound: the psychological, which evokes memories and emotions, and the neurological, which triggers biological effects at the cellular level. Sound feeds electrical impulses that charge the neocortex creating a strong brain full of neurological pathways.
- PISTA provides healing using a variety of stimuli to facilitate memory processing, which can alleviate stress, relieve pain, pacify fears, and modify maladaptive behaviors.
- For older adults with dementia and their caregivers, we found PISTA was beneficial for reducing behavioral and psychological symptoms of dementia, and reduced potential abusive behaviors of caregivers through improved mood and positive thinking.

Finding what happens inside our brain, and how our experiences connect with our unconscious and our emotions inspires neurologists, psychologists, and behavioral health specialists to figure it out. This paper introduces PISTA (Processing Inner Strength Toward Actualization (PISTA) as a sound-based intervention approach to assist older adults with psychosocial distress.

For decades, neuroscientists have recognized the importance of brain stimuli and discovered the power of sound. There are two perceptions of sound: one is psychological where sound evokes memories and emotions, and the other is neurological which triggers psychoacoustic effects. Sound triggers neurological and biological effects at the cellular level, and feeds electrical impulses that charge the neocortex creating a strong brain full of neurological pathways (Leeds, 2010). In this context, Processing Inner Strength Toward Actualization (PISTA) therapy offers a promising approach.

PISTA provides healing using a variety of stimuli to facilitate memory processing, which can alleviate stress, relieve pain, pacify fears, and modify maladaptive behaviors. Moreover, this technique can uncover inner strength allowing people to empower themselves and help cope with psychosocial stress. It is probably a coincidence that the abbreviation PISTA means "clue" in Spanish; however, this approach does provide hints to inspire individuals to understand themselves.

PISTA is based on the neuroscience of processing sound and potential therapeutic benefits. First discovered by Heinrich Wilhelm Dove in 1839, and further elaborated upon by Gerald Oster in the 1970s, a third beat (or binaural beat) is created when tones of stimuli are different in each ear. The theory explains that playing two slightly different tones syncs the brain waves in both hemispheres, a process named brainwave entrainment (Carter & Russell, 1993). Taking this into account, PISTA is a contemporary method that leverages the human auditory function to heal and improve well-being.

Ever since PISTA was used for the first time in 1983, NovaPlam Foundation, an NGO based in Hong Kong, has created different sound files of music and rhythm as stimuli, and also Transcranial Magnetic Stimulation (TMS) to promote well-being. For therapeutic purposes, the sound files are composed of two tones which the brain combines and alters into a single tone during auditory processing. The frequency of this single tone varies according to what psychological state individuals would like their brains to achieve.

Even though sound by itself can affect the way people process information, there is a therapeutic structure designed to target a mental health problem or illness. Based on each

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PISTA AS A SOUND-BASED THERAPEUTIC APPROACH TO HELP ADDRESS PSYCHOSOCIAL DISTRESS AMONG OLDER ADULTS, *continued from page 8*

individual patient case, an Entry Point (EP) consisting of a word or small phrase is created by a therapist. The EP provides a specific guide for the patient to focus attention on a particular memory, so when the sound file is heard this information is processed by the two hemispheres producing new understandings.

PISTA also takes individual psychosocial situations into account to assist with adjusting and coping with stages of development including stress associated with older age. Points of attention may include conflicting views to moral growth, interpersonal conflict, and/or social experiences associated with cognitive disequilibrium.

PISTA is a safe and individualized therapeutic technique. The patient decides on the depth and intensity of the emotions they would like to address, and the therapist develops an entry point.

The role of the therapist is to provide expertise on the method and technique, while the patient is the agent of change. The patient allows information to flow, and this provides clues for the conscience to create new understandings associated with greater wellbeing. For older adults with dementia and their caregivers, we found PISTA was beneficial for reducing behavioral and psychological symptoms of dementia and reduced potential abusive behaviors of caregivers through improved mood and positive thinking.

In conclusion, PISTA is an innovative method of therapy grounded in neuroscience that currently has promising, yet still limited, evidence to support its effectiveness. The therapeutic technique is designed to address specific mental health problems. PISTA evokes memories associated with each individual's situation, and aims to improve understanding and insight, while creating new neurological pathways, to improve mental health and quality of life.

REFERENCES:

1. *Béguin, F; Chan, S; Stang, A. (2018). To Mind and Mend: How the PISTA Method Heals and Improves Living. McGral-Hill Open Publishing.*
2. *Chaieb, L., Wilpert, E. C., Reber, T. P., & Fell, J. (2015). Auditory beat stimulation and its effects on cognition and mood States. Frontiers in psychiatry, 6, 70. https://doi.org/10.3389/fpsyt.2015.00070*
3. *Carter, J. L. and Russell, H. L. 1993. A pilot investigation of auditory and visual entrainment of brain wave activity in learning disabled boys. Texas Researcher, 4: 65–73.*
4. *Leeds, J. (2010). The power of sound: How to be healthy and productive using music and sound. Simon and Schuster.*

Dr. André Stang from Germany is an expert in understanding of the psychological impact of humans on their environment and daily performance. Trained in psychology and environmental science, he focused on the interactions occurring when "bad" chemicals cause imbalances in the human body. This knowledge, combined with his expertise in the integration of interdisciplinary methods, like psychology approaches, has contributed to his impressive track record and proven ability to improve older people's lives by promoting the best practices procedures in daily life.

Lana Chan is the founder of the Nova Palm Foundation with locations in Paris, London, Shenzhen, and Hong Kong. Nova Palm's work includes the PISTA Community Service Program for the Elderly providing both phone and in-home support along with financial aid to those in need.

Dr. Fei Sun is a professor and coordinates the Levande Geriatric Social Work Certificate program at the School of Social Work (SSW) at Michigan State University (MSU). He is a fellow of The Gerontological Society of America, and has been working with the Department of Mental Health and Substance Abuse of World Health Organization (WHO) on developing a global toolkit for dementia friendly communities. His overall research area is aging and mental health with a focus on addressing the impact of Alzheimer's disease and related disorders in Chinese American community.

SUICIDE AMONG OLDER ADULTS

Nour Awad, BS[1] and Rita Khoury, MD[2]

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Key highlights

- Although suicide attempts are more frequent among adolescents and young adults, completed suicide rates are higher among older adults, which poses a serious public health concern.
- A major risk factor of suicide in older adults is having an underlying psychiatric illness, notably a depressive disorder, which often goes undiagnosed and untreated in older adults due to lack of appropriate screening in primary care settings and reluctance to visit a mental health specialist.
- A diagnosis of a physical illness associated with loss of independence (e.g., malignancy) is associated with elevated suicidal risk in older adults, notably within 3 years of the diagnosis.
- Social factors particularly relevant to older patients including retirement, grief, social isolation, and financial strain, are associated with increased suicidal risk.
- Preventative strategies include improving detection and referral for affective disorders, maximizing resilience and enhancing social support for older adults. Innovative technology-based platforms have emerged as effective strategies to monitor mood and suicidal thoughts, while providing support and treatment options in this population (i.e., mental health consultation, counseling, etc.).

INTRODUCTION

According to the National Center for Health Statistics (NCHS), nearly 45,799 American individuals died by suicide in 2020, which is a 30% increase compared to the year 2000 [(1)]. The Center for Disease Control (CDC) reported that 12.2 million adults in the United States considered suicide in 2020; 3.2 million planned it, and 1.2 million attempted suicide [(2)]. Suicide has a substantial public health impact, and can be preventable. Although suicide attempts are more frequent among adolescents and young adults, completed suicide rates are higher among older adults. Older adults are not a homogeneous group: the "youngest old" are between the ages of 65 and 74; the "middle aged" are between the ages of 75 and 84; and the "oldest old" are over the age of 85. The CDC (2020) reports that men over the age of 75 had the highest suicide rate (40.5 per 100,000) compared to other age groups [(3)]. We will review the risk factors of suicide among older individuals, as well as preventative strategies in this population.

RISK FACTORS

Among all predictors of suicide in older adults, psychiatric disorders emerge as the most robust and most common. Psychiatric illness is present in 71-97% of elder suicides, with affective disorders being the most common, in particular major depression [(4)]. Unfortunately, affective disorders are often underdiagnosed and undertreated in primary care settings. Other mental disorders associated with high suicide risk are bipolar disorder, anxiety disorders, neurocognitive disorders/dementia and alcohol use disorder [(5)]. Individuals with dementia had an increased risk of suicide within one year following diagnosis compared to those without dementia. While patients with severe dementia are usually protected against suicide given their inability to organize

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a suicidal plan, those with early dementia may maintain capacity to carry out a suicidal plan due to better cognition and insight into their illness [6].

Other predictors of suicide in older adults include physical illnesses, notably within three years of diagnosis, and when associated with loss of independence. Elevated suicide risk has been associated with lung cancer, gastrointestinal cancer, breast cancer, genital cancer, bladder cancer, lymph node cancer, epilepsy, cerebrovascular diseases, cataracts, heart diseases, chronic obstructive pulmonary disorders (COPD), gastrointestinal disease, liver disease, arthritis, osteoporosis, prostate disorders, male genital disorders, and spinal fractures within three years of diagnosis compared to individuals without these conditions [7]. Also, social factors including grief, social isolation and financial constraints are risk factors for suicide by triggering depression or other psychiatric disorders.

The method of suicide varies according to gender, country, and culture. Hanging, pesticide self-poisoning, and firearms are the most common methods irrespective of country-specific patterns; in western countries poisoning is the most common in older adult women, and firearms are the most common for older adult men [8].

A previous suicidal attempt was associated with an almost 20-fold increase in the odds of another suicidal attempt [9]. Male gender, greatest severity of lifetime suicidal ideation, and deficits in cognitive control independently predicted fatal/near-fatal suicidal behavior in older adults, while introversion, history of suicide attempt, and earlier age of onset of depression predicted less lethal suicidal behavior [10]. In comparison to suicide attempts in younger persons, attempts in older adults are more deliberate and more likely to succeed. Although females are shown to have a greater number of suicidal attempts, males have higher rates of

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SLU "AM SAD" Tool

(Validated Geriatric Depression Screening Tool)[**]

SAINT LOUIS UNIVERSITY

AM SAD	Question	Frequency (Points)			Point(s)
A (Appetite)	Within the past 2 weeks, how many times have you experienced **unexplained change in appetite**	Never (0)	One Day (1)	More than One Day (2)	
M (Mood)	Within the past 2 weeks, how many times have you experienced **unexplained lowered mood on a day to day basis?**	Never (0)	One Day (1)	More than One Day (2)	
S (Sleep)	Within the past 2 weeks, how many times have you experienced **unexplained disturbed sleep?**	Never (0)	One Day (1)	More than One Day (2)	
A (Activity & Energy)	Within the past 2 weeks, how many times have you experienced **less energy or not being interested in performing your usual daily activities?**	Never (0)	One Day (1)	More than One Day (2)	
D (Death or Worthlessness)	Within the past 2 weeks, how many times have you experienced **feelings of worthlessness or guilt or that your life is not worth living?**	Never (0)	One Day (1)	More than One Day (2)	

TOTAL POINTS /10

Total Points	Inference
0-2	No Depression
3-5	Mild Depression
6-10	Moderate /Severe Depression

[**] Chakkamparambil B, Chibnall JT, Graypel EA, Manepalli JN[1], Bhutto A, Grossberg GT. Development of a Brief Validated Geriatric Depression Screening Tool: The SLU "AM SAD". Am J Geriatr Psychiatry. 2014 Oct 16

Table 1 The Saint Louis University AMSAD assessment tool for depression in older adults with or without dementia [12, 13].

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completed suicide. Older adults often have underlying health conditions which reduce odds of survival in comparison to suicidal attempts in younger persons [8].

PREVENTATIVE STRATEGIES

The first approach involves the diagnosis and treatment of psychiatric disorders to prevent suicidal behavior. Research indicates older adults typically communicate to their general practitioner their suicidal thoughts within one month prior to the attempt, and only 20% of older adults would have consulted a psychiatrist [11]. Hence, there is a need to train primary care physicians about diagnostic criteria and management of affective disorders in older adults, in addition to implementing a systematic screening system for suicidal thoughts and behaviors with an appropriate referral. The Saint Louis University (SLU) AMSAD depression scale is a short (5-item) screening and diagnosis tool for older adults with or without dementia [12, 13], which is recommended to general practitioners for use in busy clinical settings (***Figure 1***). Other preventive strategies include phone hotlines, risk assessment tools, and preventing access to common methods of self-injury (e.g., loaded firearms, illegal drugs, bridges, high places, etc.). Increasing accessibility to counseling services is also key. Among psychotherapy techniques, cognitive behavioral therapy (CBT) has been found to be the most effective in older adults, either by targeting the suicidal thoughts directly or the symptoms of anxiety and depression [14].

Another essential pillar of suicide prevention in older adults is providing social support and companionship. The CDC identified promoting connectedness at personal, family, and community levels as a key strategy to prevent suicidal behavior at all ages, and in particularly older adults who more commonly suffer from social isolation [4]. Remote interventions have been frequently used during the COVID-19 pandemic. Through online support groups, web chatting, and increased virtual awareness campaigns, communities have rallied volunteers to assist older individuals in strengthening social networks, and providing psychoeducation and referral information. Telecommunication studies have shown that face-to-face contact may not be required for successful mental health care interventions. In vulnerable, older adults who may be struggling with transportation and/or mobility issues, telephone outreach programs are promising strategies for providing social support, improving resilience, managing mental health problems, and preventing suicidality. Tailored web-based, interactive programs focusing on positive aging, quality of life, social skills, sense of belonging, reasons for living, hope, meaning in life, religiosity/spirituality, and even humor are innovative and promising ways to prevent suicide in older adults [15].

In a qualitative pilot study, older adults reported being motivated to use digital technology to support their mental health, promote self-reliance, avert loneliness, and improve their mood. Applications and websites must however address accessibility and universal, simple design features to maximize their usability, in order to reach as many older users as possible, rather than assuming prior knowledge in this population [16].

REFERENCES:

1. *Hedegaard H, Curtin S, Warner M. Increase in Suicide Mortality in the United States, 1999-2018. NCHS data brief. 2020:1-8.*
2. *Ehlman DC, Yard E, Stone DM, Jones CM, Mack KA. Changes in Suicide Rates - United States, 2019 and 2020. MMWR Morbidity and mortality weekly report. 2022;71(8):306-12. https://www.cdc.gov/suicide/facts/disparities-in-suicide.html*
3. *Conwell Y, Van Orden K, Caine ED. Suicide in older adults. Psychiatr Clin North Am. 2011;34(2):451-ix.*
4. *Kułak-Bejda A, Bejda G, Waszkiewicz N. Mental Disorders, Cognitive Impairment and the Risk of Suicide in Older Adults. Front Psychiatry. 2021;12:695286-.*
5. *Choi JW, Lee KS, Han E. Suicide risk within 1 year of dementia diagnosis in older adults: a nationwide retrospective cohort study. J Psychiatry Neurosci. 2021;46(1):E119-E27.*
6. *Erlangsen A, Stenager E, Conwell Y. Physical diseases as predictors of suicide in older adults: a nationwide, register-based cohort study. Social Psychiatry and Psychiatric Epidemiology. 2015;50:1427-39.*
7. *Obuobi-Donkor G, Nkire N, Agyapong VIO. Prevalence of Major Depressive Disorder and Correlates of Thoughts of Death, Suicidal Behaviour, and Death by Suicide in the Geriatric Population-A General Review of Literature. Behav Sci (Basel).*

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2021;11(11):142.

8. *Wiktorsson S, Runeson B, Skoog I, Ostling S, Waern M. Attempted suicide in the elderly: characteristics of suicide attempters 70 years and older and a general population comparison group. The American journal of geriatric psychiatry: official journal of the American Association for Geriatric Psychiatry. 2010;18(1):57-67.*
9. *Szanto K, Galfalvy H, Kenneally L, Almasi R, Dombrovski AY. Predictors of serious suicidal behavior in late-life depression. European Neuropsychopharmacology. 2020;40:85-98.*
10. *Conejero I, Olié E, Courtet P, Calati R. Suicide in older adults: current perspectives. Clin Interv Aging. 2018;13:691-9.*
11. *Chakkamparambil B, Chibnall J, Gao X, Xin J, Khoury R, Grossberg GT. The SLU-AMSAD, a short screening tool for diagnosing depression in dementia patients. Alzheimer's & Dementia. 2021;17(S7):e057550.*
12. *Khoury R, Chakkamparambil B, Chibnall J, Rajamanickam J, Kumar A, Grossberg GT. Diagnostic Accuracy of the SLU AMSAD Scale for Depression in Older Adults Without Dementia. Journal of the American Medical Directors Association. 2020;21(5):665-8.*
13. *Okolie C, Dennis M, Simon Thomas E, John A. A systematic review of interventions to prevent suicidal behaviors and reduce suicidal ideation in older people. Int Psychogeriatr. 2017;29(11):1801-24.*
14. *Lapierre S, Erlangsen A, Waern M, De Leo D, Oyama H, Scocco P, et al. A systematic review of elderly suicide prevention programs. Crisis. 2011;32(2):88-98.*
15. *Andrews JA, Brown LJ, Hawley MS, Astell AJ. Older Adults' Perspectives on Using Digital Technology to Maintain Good Mental Health: Interactive Group Study. J Med Internet Res. 2019;21(2):e11694-e.*

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SUICIDE RATES IN OLDER SPANISH ADULTS DURING THE COVID-19 PANDEMIC IN 2020

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Key highlights

- Higher rates of suicidal behaviors were detected during 2020 in Spain.
- Suicide rates in adults greater than 80 years of age increased over 20% compared to previous year.
- It is important to reduce suicide risk factors and promote protective factors in this population.

In studies of suicidal behavior in older adults over 65 years of age, multiple risk factors have been identified. Some of these risk factors are, for example, sex (male), the presence of chronic and/or disabling diseases, psychopathological disorders (e.g., depression), toxic substance use (such as alcohol), institutionalization in care homes, adverse life experiences (e.g., grief), lack of social support, and social isolation.

On the other hand, protective factors against suicidal behavior include adequate family support, integration into an adequate social network, and also the ability to access community health services.

SUICIDE RATES IN OLDER SPANISH ADULTS DURING THE COVID-19 PANDEMIC IN 2020, *continued on next page*

SUICIDE RATES IN OLDER SPANISH ADULTS DURING THE COVID-19 PANDEMIC IN 2020, *continued from page 13*

The COVID-19 pandemic has affected our society in most domains including social, economic, physical and mental which has been more evident in extreme age groups (childhood-adolescence and older adults). At the start of the pandemic, home lockdown was decreed in Spain on 14 March 2020 to reduce the number of contacts and stop the spread of the virus as much as possible. This lockdown lasted until 21 June of that same year, which meant that many individuals and couples had to stay home without being able to interact with family, friends or their usual social network. The lockdown increased risk factors such as loneliness, and increased anxiety levels in the face of fear of illness, while worsening protective factors like adequate family support and the support of social and community health networks.

Over time, data reflecting this great impact is starting to be published. Data for the year 2020 have recently been published by the Spanish National Statistics Institute and later by the Suicide Observatory in Spain (of the Spanish Foundation for Suicide Prevention). In their report, 3,941 completed suicides were reported (74% males, 26% women) which is the highest number of suicides in Spain since records have been recorded; an increase of 5.7% in men and 12.3% in women compared to 2019 was described in the Observatory. Of the 3,941 suicides, 1,608 were found in those over 60 years of age (40.8%), and in those over 80 years of age, there was a 20% increase in suicide rate compared to 2019.

De la Torre-Luque et al. report a significant relationship between the suicide rate and the timing of the pandemic: during the lockdown period of 2020, the suicide rate was lower compared to the same period of 2019. After the lockdown was finished, the suicide rate rates increased rapidly. This increase has not been seen in other countries, now with other results being published. Thus, for example, in Finland, in a recent article published by Partonen T and collaborators, there has been no increase in the number of suicides throughout 2020. In Japan, the suicide rate increased 16% during the second wave of the pandemic from July to October 2020. More data will be needed to observe trends and draw further conclusions from 2021 and beyond.

However, these results, although preliminary, make it necessary to focus our efforts on promoting and re-establishing social support networks for older adults, especially now that they can once again access the health system and connect in-person with family members.

For further reading:

(1) *Wand APF, Zhong B, Chiu HFK, Draper B, De Leo D. COVID-19: the implications for suicide in older adults. International psychogeriatrics 2020;32(10):1225-1230.*

(2) *Tanaka T, Okamoto S. Increase in suicide following an initial decline during the COVID-19 pandemic in Japan. Nature human behaviour 2021;5(2):229-238.*

(3) *de la Torre-Luque A, Pemau A, Perez-Sola V, Ayuso-Mateos JL. Suicide mortality in Spain in 2020: The impact of the COVID-19 pandemic. Revista de psiquiatría y salud mental 2022.*

(4) *Partonen T, Kiviruusu O, Grainger M, Suvisaari J, Eklin A, Virtanen A, et al. Suicides from 2016 to 2020 in Finland and the effect of the COVID-19 pandemic. The British Journal of Psychiatry 2022;220(1):38-40.*

(5) *Observatorio del suicidio. Fundacion española para la prevención del suicidio (Spanish Foundation for suicide prevention): https://www.fsme.es/observatorio-del-suicidio/*

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RECOGNITION, PREVENTION AND TREATMENT OF WERNICKE-KORSAKOFF SYNDROME (WKS): AN INFREQUENT YET PREVENTABLE CAUSE OF COGNITITIVE DYSFUCTION AND NEUROLOGICAL DAMAGE

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Key highlights

- Wernicke-Korsakoff syndrome (WKS) is a neurological disorder caused by thiamine (vitamin B1) deficiency due to malnutrition in chronic alcohol consumption but also in other less recognised conditions that include vomiting, massive weight loss and thiamine deficiency nutrition such as cancer, chronic inflammatory disease, prologed fasting, hyperemesis gracvidarum and anorexia nervosa.
- The acute (Wernicke) form is defined by the classic triad of symptoms: altered mental status, ocular signs, and ataxia while the chronic irreversible syndrome is called Korsakoff's characterized by amnestic and behavioral disorders
- Alcohlic and non alcoholic pathogenesis may be different, with mechanism of neurotoxocity not fully understood but responsive to high dose thiamine treatment
- Thiamine requirements can differ among different patients, however replacement must early and adequate with high dosage of parenteral thiamine in order to prevent progression of brain damage and reverse symptoms.

Introduction: Wernicke-Korsakoff syndrome (WKS) is a neurological disorder caused by thiamine (vitamin B1) deficiency. Its acute form Wernicke's syndrome is characterized by the classic triad of symtoms: confusion, ataxia, and eye-movement disorders, while the chronic, irreversible form results in the amnestic and behavioral syndrome, known as Korsakoff's syndrome. When presenting together, the patient can be defined to suffer from Wernicke-Korsakoff's syndrome. The pathogensis of WKS is attributed to alcohol abuse or other less known causes of nutritional deficits, such as hyperemesis gravidarum, cancer, bariatric surgery, hunger strike, soft drink consumption in the pediatric population, anorexia nervosa, or inflammatory bowel diseases. While the incidence of WKS is better known in alcoholic patients, the occurance related to other conditions is often underestimated. Also, the risks of suboptimal thiamine replacement in WKS either in relation to dose or duration are not fully known.

Description: Vitamin B1 is required in the Krebs cycle for production of adenosine triphosphate (ATP). It is also a cofactor in the production of acetylcholine and certain neurotransmitters. Thiamine deficiency is common in chronic alcohol abuse because of the poor nutritional content of alcohol as the main msource of calories. Moreover, thiamine as a vitamin is not stored in the body, and without repletion reserves are consumed in 10-14 days. Although the exact pathogenesis of neurotoxicitiy cahracteristic of certain brain regions in WKS is not fully understood, it is known that administration of thiamine can prevent neurological damage.

The acute phase of WKS was characterized by Carl Wernicke in 1881, as the triad: altered mental status, ocular signs, and ataxia. The chronic phase of WKS, called Korsakoff's syndrome (KS), was described by Sergei Korsakoff in 1887, as an amnesic disorder with confabulations. However, alcohol consumption is not the only etiology of WKS: conditions like prolonged fasting, anorexia nervosa, or a diet of polished rice are also associated with thiamine deficincy. Additional less known causes are parenteral nutrition without thiamine in malnourished individuals and formulas without thiamine in little children. Other conditions increasing risk are vomiting

RECOGNITION, PREVENTION AND TREATMENT OF WERNICKE-KORSAKOFF SYNDROME (WKS), *continued on next page*

RECOGNITION, PREVENTION AND TREATMENT OF WERNICKE-KORSAKOFF SYNDROME (WKS), *continued from page 15*

or chronic diarrhea, hyperemesis gravidarum in pregnant women, obese patients after bariatric surgery, inflammatory bowel diseases, or malnourishment in oncologic patients. WKS unrealted to alcohol use is more common in realtively younger populations, and WKS appears to be more frequent in females compared to males. Early indicators of nonalcoholic WKS are vomiting and significant weight loss. Imaging findings assocaited with WKS include atrophy of the thalamus, mammillary bodies and/or periaqueductal gray matter.

Treatment and Outcome: If undetected or untreated, WKS is progressive and irreversible. Also, negative outcomes are assocaited with undertreatment of WKS with too low of thaiamine dose. Oral administration of the usual 300 mg of thiamine is not sufficient in preventing WKS for those with vomiting and weight loss including pregnant women and infants and children. Some authors suggests parenteral thiamine treatment of 300-500mg, three times a day before glucose load during the acute phase and until the nutritional deficit has been corrected. Studies suggest that the pathology of WKS is different between nonalcoholic and alcoholic patients, with the latter requiring higher doses of thiamine repletion. Also, responses are variable with some patients requiring relatively higher doses (over 1g of parenteral thiamine) and others responding to lower doses. Sometimes other coexisting nutritional deficiencies, such as magnesium, folate, or other B complex vitamins, must be corrected in order to allow thiamine to function. Intramuscular administration of Vitamin B1 seems to have a lower incidence of anaphylactic reactions compared to IV, and oral administration has the lowest risk.

Conclusion: Unlike many other forms of cognitive dysfucntion and neurological damage, thiamine deficiency is preventable and treatable. Increased awareness of WKS and greater recognition of early warning signs in nonalcohol-related cases, like vomiting and weight loss, should be prioritized. Prophylactic treatment with parenteral thiamine should be initiated in those at risk for nutritional deficiency even when WKS is only suspected. Treatment dose and duration should be adequate, in order to prevent irrversible brain damage.

REFERENCES:

1. *Oudman E, Wijnia JW, Oey MJ, van Dam M, Postma A. Wernicke-Korsakoff syndrome despite no alcohol abuse: A summary of systematic reports. J Neurol Sci. 2021 Jul 15;426:117482. doi: 10.1016/j.jns.2021.117482. Epub 2021 May 7. PMID: 34000679.*
2. *Popa I, Rădulescu I, Drăgoi AM, Trifu S, Cristea MB. Korsakoff syndrome: An overlook (Review). Exp Ther Med. 2021 Oct;22(4):1132. doi: 10.3892/etm.2021.10566. Epub 2021 Aug 5. PMID: 34466144; PMCID: PMC8383329.*

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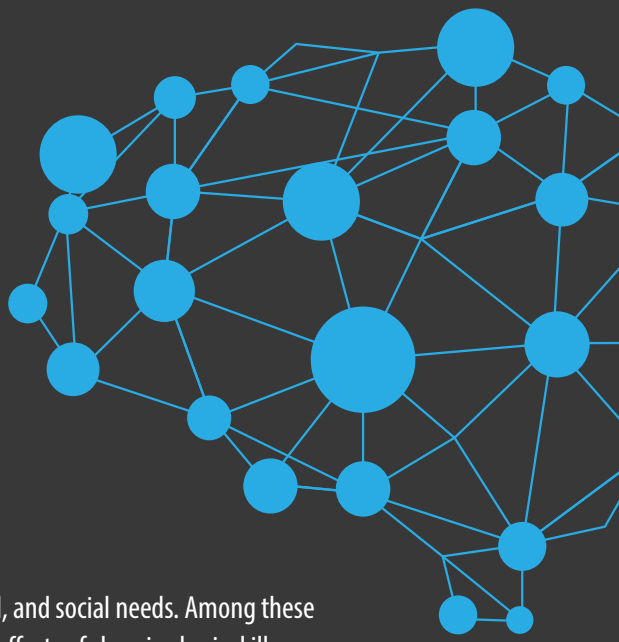
International Psychogeriatric Association
Better Mental Health for Older People

alzheimer's association

GLOBAL PERSPECTIVES ON MENTAL HEALTH OF OLDER ADULTS:

A PRIMER FOR CLINICIANS



The world's population is aging and older adults have special mental, physical, emotional, and social needs. Among these include dementia, late life depression, anxiety and sleep disorders, as well as psychiatric effects of chronic physical illness. Numerous studies have confirmed the increasing incidence of mental illness among older adults as well as a decrease in specialists serving the mental health needs of this aging population.

This course provides older adult mental health training for physicians and allied health professionals who work - but do not necessarily have advanced training - in older adult mental health.

With 12 seminars to choose from, expand your knowledge and understanding of important concepts in older adult mental health. CME is available following completion of each seminar.

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This Primer is free (registration required) for IPA and ISTAART members. For all others, there is a nominal fee ($25 USD) for the full course. *(ISTAART members please contact the ISTAART office for your registration code.)*

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  Behavioral and Psychological Symptoms of Dementia (BPSD): Pharmacologic Treatment Approaches
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- Delirium in Older Adults: Challenges in Diagnosis and Management
  Dementia Early Stages and Prevention
- Geriatric Depression
- Human Rights Frameworks; A UN Treaty for Older People's Human Rights, Capacity Assessment
- Non-Alzheimer's Dementia
- Palliative Care in People with Dementia
  Prevention of Suicide in Later Life: Clinical and Public Health Perspectives
- Psychological Aspects of Aging: Concepts of Successful Aging, Resilience, Wisdom and Impact
- Sleep Disorders in the Elderly

THE AGEING SCIENTIST – MAKING DEMENTIA AND AGEING RESEARCH MORE ACCESSIBLE

Dr Clarissa Giebel, PhD
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One year ago now, The Ageing Scientist podcast launched. Podcasts have had a surge during the pandemic, but the idea of hosting my own podcast had been in the back of my mind for a while.

As researchers, we try to improve the lives of people, but this can take a long time. In my area of dementia research, even when knowing precisely how barriers of care can prevent those with the condition and their caregivers from accessing help and suitable interventions, implementing them into practice can take a very long time.

It is not only about how long it takes though to try to make an impact with your research. Research can also far too often stay in that academic bubble; often we publish things and move on without really sharing findings and discussing research with people who are working in the field or who have personal experiences.

That was one reason why I set up the Liverpool Dementia & Ageing Research Forum in 2019, where research can be shared freely and widely via regular seminars, webinars, and an annual conference. However, seminars only take place every two months, and not everyone can make it at that scheduled time.

Creating a podcast however is an added layer of accessibility to the latest dementia and ageing research. It is easy to access the podcast on Podbean, Spotify, or Apple Music at any point in time. One of the best things about the podcast is that I can connect with more experts in field about their work and lived experiences.

Every three months, a new podcast season is released. Past seasons have focused on COVID-19, ageing well, the basics of dementia, and health inequalities. Each season has a number of episodes with different professional and lived experts, and there are plenty of carers and care providers involved. IPA members are on the panels also, so keep an ear out to spot some of them!

For the upcoming season (Season 5), launching on the 1 June 2022, I have spoken with a number of professionals and carers about Care homes. Topics range from human rights and innovative long-term care, to family carers and big data; it is always a learning experience too for me to hear from invited guests.

If you work in the ageing and dementia field and are interested in joining the podcast as a guest panelist, please drop me an email. I will see how your backgrounds fits into a specific season topic (Email: Clarissa.giebel@liverpool.ac.uk). Most importantly, have a listen to the podcast here: https://liverpooldementiaageingresearchforum.co.uk/the-ageing-scientist-podcast/

Dr Clarissa Giebel is Senior Research Fellow at the University of Liverpool and directs research on inequities in dementia social care. She is working both nationally and internationally to address these inequities, and aims to enable every person with dementia to live well and independently at home.

MENTAL HEALTHCARE SERVICE AT BAN THAMMAPAKORN LONG-TERM CARE FACILITY DURING THE COVID-19 OUTBREAK

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Key highlights

- Proactive mental health service aimed at preventing recurrence of mental illness in residents of long-term care (LTC) facilities is important.
- Providing mental healthcare during the pandemic was challenging, and the implementation of telehealth facilitated this process.
- Mental healthcare teams working in LTC facilities need to provide mental health services and COVID-19 education.
- Mental healthcare services should be provided to both the residents and staff of LTC facilities.

COVID-19 OUTBREAK AT THE "BAN THAMMAPAKORN" LONG-TERM CARE FACILITY

In Thailand, nearly 4.4 million people have been infected with the COVID-19 and nearly 30,000 people have died. Although the pandemic situation is much better, older people still have high morbidity and mortality. Since the first few months of the pandemic in 2020, our geriatric mental health team at the Thammapakorn Social Welfare Development Center for Older Persons (BT), telehealth has become the primary method of treatment for the residents. BT has about 120 residents, and about half suffer from mental illnesses, such as depression, bipolar disorders, and neurocognitive disorders.

The news of COVID-19 spreading in BT in late October 2021 caused great concern and panic among Thai people, as it was the first COVID-19 spread in an LTC facility in Thailand. Fortunately, the residents had already received two doses of the COVID-19 vaccine in September 2021.

The first cluster of COVID-19 cases was detected in several residents and a few staff, which later spread to about 90% of the residents and nearly 20 staff within a single week. Over a 30-day period, we had to increase the number of patient visits, establish regular treatment team meetings, and carefully monitor the situation day-by-day. It was an exciting, yet stressful, experience which was great for our learning. The majority of residents received treatment and recovered well; however, two of the cases unfortunately passed away. We summarize the after-action review among team members after the situation had returned back to normal.

SUANDOK-THAMMAPAKORN TELEHEALTH TEAM

Since the first year of the pandemic, geriatric mental health team (GMHT) services have been regularly provided using Suandok-Thammapakorn Telehealth operated by the Microsoft (MS) Teams application. The GMHT from Maharaj Nakorn Chiang Mai Hospital, Faculty of Medicine, Chiang Mai University, is comprised of two geriatric psychiatrists, several psychiatry residents, four nurses, one occupational therapist (OT), one psychologist, two pharmacists, and several caregivers.

OUTBREAK NOTIFICATION AT BT

After the first suspected cases of COVID-19 were confirmed, the geriatric psychiatrist who leads the GMHT was informed by the team health promotion nurse and case manager; this information was then distributed among the team via MS Teams chat.

MENTAL HEALTHCARE SERVICE AT BAN THAMMAPAKORN LONG-TERM CARE FACILITY DURING THE COVID-19 OUTBREAK, *continued on next page*

MENTAL HEALTHCARE SERVICE AT BAN THAMMAPAKORN LONG-TERM CARE FACILITY DURING THE COVID-19 OUTBREAK, *continued from page 19*

TEAM LEADER AND TEAM MANAGER

A geriatric psychiatrist is the team leader while the health promotion nurse is a case manager. The case manager communicated with both the GMHT and the Infection Control (IC) team every day. The manager also summarized the daily progression of the residents' physical health and updated the mental health team.

TEAM MEMBER COMMUNICATION

Before the outbreak team members met monthly for a case conference. During this outbreak, the mental health team conducted daily reports and evaluated high-risk patients 3 times per week. The managing nurses had a meeting every day and routinely transferred information from the IC team to the mental health team. The LINE software application was also used to connect with the infection control department and among individuals.

MENTAL HEALTH SERVICES DURING THE OUTBREAK

Plan Phase

The geriatric psychiatrist called for an urgent meeting which took place using MS Teams chat and lasted about one hour. The plan was about short-term mental health management within one week, and was divided into an ultra-short plan for day-to-day service and weekly team goals.

Crisis Intervention Phase

The geriatric psychiatrist devised a plan to screen for residents at high risk of mental health relapse or recurrence, and they were evaluated by the team within the first week. The mental health service also covered the residents who had not been seen by the GMHT before. Patients were screened with the Fear of COVID-19 and Impact on Quality of Life scales, and consultation was recommended to residents with high scores.

Psychotropic medications and virtual psychosocial interventions were provided by a psychiatrist, OT, and psychologist, either together or separately. Pharmacists were on standby for consultation about any drug-drug interactions, and every infected resident received casirivimab and Imdevimab.

PRIORITIES AND OBJECTIVES IN GMHT SERVICE DURING OUTBREAK

The primary aim of the service as established by the geriatric psychiatrist was to: (1) reduce the number of new cases of mental illness to zero, (2) minimize relapse and recurrence of mental illness, (3) achieve zero mortality and zero occurrence of transfer to the inpatient mental healthcare unit. The secondary aim set by the geriatric psychiatrist was to benefit the staff working at BT. The team was working against the clock and had to be proactive to anticipate changes.

ROLES AND RESPONSIBILITIES OF TEAM MEMBERS DURING OUTBREAK

The geriatric psychiatrist's primary role was a leading role in diagnosing mental illness and treatment planning with the biopsychosocial approach. **Nurses** screened residents, both infected and non-infected by COVID-19, at high risk of mental health problems and those currently struggling with s mental illness. The **occupational therapist** had a supportive role in providing counseling to residents and staff. **Clinical psychologists provided** Art Therapy through painting and picture immersion to assist with identifying emotions and to promote feelings of wellbeing

Mental Health Support for LTC facility staff

Staff and caregivers were quarantined and treated at BT until the final case completed treatment. The GMHT provided individual supportive psychotherapy for both infected and non-infected persons, and psychological support for staff was important and necessary. Although both staff and residents received treatment for COVID-19, the residents still needed caregiving from the staff.

Destigmatization Phase

After the third week of the outbreak, the team called for a meeting to plan for the destigmatization phase among all residents within the following week. The team evaluated non-infected residents about their attitudes toward the infected residents, and residents were provided with knowledge about COVID-19. Finally, non-infected residents were asked to join the activity, "Welcome back home, Buddy!".

MENTAL HEALTHCARE SERVICE AT BAN THAMMAPAKORN LONG-TERM CARE FACILITY DURING THE COVID-19 OUTBREAK, *continued on next page*

MENTAL HEALTHCARE SERVICE AT BAN THAMMAPAKORN LONG-TERM CARE FACILITY DURING THE COVID-19 OUTBREAK, *continued from page 20*

BARRIERS AND CHALLENGES

The psychiatrists shared that the biggest challenge was the busy schedule and the greater responsibility. Nurses added that poor internet connectivity at times disturbed communication between the care team and residents who were already sensory deprived. Some residents who had never been seen by the GMHT were reluctant to meet with the team which could delay treatment. Also, mobile devices were not suitable for telehealth as the device screen was too small and the speaker volume was too low.

LESSONS LEARNED

Crisis intervention should be a core principle in managing mental health during the outbreak. Nurses report learning new skills like managing care for COVID-19 patients and vaccine management. Also, nurses report learning 'Tolerance' during such a highly demanding and unpredictable situation; they also learned more about the unique community and environment of BT. The occupational therapist appreciated the self-protection measures, because it seemed 'Even though the residents stayed in only, many of them still got infected'. The clinical psychologist emphasized the importance of 'psychological First Aid' to us as well. She also shared the importance of 'Opening yourselves to opportunities by seeking new knowledge about COVID-19, treatments, and preventions.'

REFERENCES:

1. *Wongpakaran, N.; Wongpakaran, T.; Tangjitboonsanga, N.; Kaewkittikul, K.; Nantasen, I. COVID-READY guidelines help healthcare providers evaluate psychological coping strategies among older adults: Thai perspectives. IPA Bulletin 2020, 37, 15-17.*
2. *Wongpakaran, T. Fear of COVID-19 and impact on QoL Scale. Available online: http://www.wongpakaran.com/index.php?lay=show&ac=article&Id=2147599077 (accessed on 3rd April 2022).*
3. *Wongpakaran, N.; Nantasen, I.; Kungvong, N.; Wongpakaran, T.; Siri-ai, Y.; Varnado, P. Using Telehealth in long-term care facility: an experience from Thailand. IPA Bulletin 2020, 20-23.*