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GUEST EDITORIAL

The International Psychogeriatric Association: building on 25 years of leadership and vision

The International Psychogeriatric Association (IPA) was founded 25 years ago as a multidisciplinary organization with the ambitious vision of improving the mental health of the elderly around the world. For a variety of reasons, some leaders were skeptical about the value of an international organization and it was the vision and energy of Dr. Sanford Finkel, together with a relatively small group of colleagues, who brought IPA to life and nurtured it through its infancy. Dr. Finkel, known to all as Sandy, has chronicled some of the history of IPA elsewhere and I won't repeat it here other than to emphasize the profound effect that IPA's first executive director, the dedicated and beloved Fern Finkel, had on IPA until her retirement in 2006. The importance of IPA as a leading professional organization is now well established, but beyond its many achievements in molding and guiding the profession, IPA is also a professional home for our members, a place of intellectual comfort where colleagues speak a common language and share common goals. Within IPA we can relax, share universal concerns for the ambivalently viewed population of elders that the world worries about but often avoids or ignores at the same time. We can share our challenges and they are many, our hopes, our successes and our uncertainties.

The past 25 years have seen seminal changes in the field of psychogeriatrics, and IPA and its leading members have been at the forefront of guiding these developments. Of particular influence were the advances made during the 1990s which were heavily dominated by research and clinical foci on the brain that received strong financial incentives from both government and industry. This produced transformative change in the field including the first generation of practical cognitive enhancers, new generation antipsychotics and antidepressants, genetic knowledge, neuroimaging techniques and knowledge of basic mechanisms of disease. IPA's nine consensus conferences reflected the hope and excitement of these advances and since 1994 have focused on various aspects of dementia such as coining, refining and disseminating the seminal concept of behavioral and psychological symptoms of dementia (Landsdowne, U.S.A., 1996 and 1999), defining frameworks for measuring outcomes in dementia research (New York, 1994 and Canterbury, England, 2006), refining therapeutic directions for vascular change in the brain (Madrid, 2001), and crystallizing diagnostic consensus on Alzheimer's disease (Geneva, 1996), dementia with Lewy bodies (Budapest, 2002), agitation in dementia (Lisbon, 2003), and mild cognitive impairment (Bethesda, U.S.A., 2005). Despite the field's dramatic progress in understanding the dementias, we have a long way to go in educating

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policy-makers and legislators who are often unwittingly restricted in their perspectives by what Robert Butler first called agism, i.e. prejudice against elders on the basis of misunderstanding and presumptions about illnesses of old age – a subtle form of dehumanizing that relegates the old to second class or hopeless simply on the basis of age.

IPA's focus on dementia has been indisputably productive but psychogeriatrics is of course far more complex and multifaceted than one disease. From its inception IPA has been defined by a determination to embrace the breadth of psychogeriatrics. I suggest that one of IPA's important contributions has derived from its determination to maintain breadth of perspective and avoid the temptation to narrow to the diagnostic, discipline or treatment foci that define other worthy international organizations in the field. In this regard, I believe that frequent reflection about our field is essential. While we have made remarkable advances in the biological sciences, for example, the impact on clinical outcomes is still very modest. We need to continue to embrace the full array of interventions and understandings afforded by the rich diversity of theories and treatments which characterize psychogeriatric practice.

IPA's broad perspective and influence are evident in the themes and content of its regional meetings and 12 biennial congresses over the past 25 years. In itself this philosophy is courageous because it poses challenges. No doubt it is easier to manage and measure a more focused mandate. But if we narrow our focus too much we risk neglecting the key defining element of psychogeriatrics – its complexity. Indeed, from time to time more outspoken members of IPA have come forward to ask that we remedy what they consider an unhelpful tilt to narrow diagnostic categories such as dementia and depression or to the biological sciences. Such reminders are important because psychogeriatrics is far more than a neurobiological science. Aging is characterized by all the challenges to mental health of adults of all ages but the context in which these challenges occur, their sometimes unique clinical presentations, their universal comorbid features, and the chronic and recurrent nature of psychogeriatric illness must all be considered in our discipline.

The leadership of IPA has been acutely aware that great scientific advances in knowledge and treatment will only be useful to patients if they are translated into effective policies and services tailored to different elderly populations worldwide. In 2006, in a bid to meet the challenge of the patently wide variability of access to services around the world, IPA adopted a new priority strategy of public policy and advocacy with the goal of improving access, legislation and policies for mental health of the elderly. Many locales have strong legislation and services while others are less advanced in their processes. Sometimes, an extensive array of services and legislation such as in the U.S.A. is challenged by a highly complex system that elders have to deal with in order to make the best use of well-meaning and often very useful programs. These issues are particularly relevant for immigrants and isolated frail elders. Table 1 gives a sample of the array of legislative and service development in several countries.

IPA could not expect to address its ambitious goals without strong partnerships. Over the past 25 years a very large network of organizations and leaders have emerged in various countries of the world, many acting in

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Table 1. Legislation and program development: a sample from selected countries

COUNTRY	LEGISLATION/KEY PROGRAMS
Argentina	General psychiatry, neurology or geriatric services responsible for aged patients; a few programs with old age mental health professionals; two chairs in old age psychiatry in public general hospitals in Buenos Aires; two geriatric neuropsychiatry units in public psychiatric institutions in Buenos Aires (Jose T Borda Hospital for men, Braulio Moyano for women); ten public and private dementia/memory centers.
Australia	Guardianship laws; large psychiatric hospitals replaced by small inpatient units (some dedicated to aged psychiatry) in general or aged care hospitals. Community mental health teams, some devoted to older patients.
Brazil	Law for old persons (Estatuto do Idoso) and National Policy for Mental Health (national program for deinstitutionalization)
Canada	Provincial legislation (called Acts) in every province for guardianship, nursing homes, social legislation and driving; some centralized "one stop shops" to simplify access to services (e.g. Ontario's Community Care Access Centres); national guidelines for long-term care management of depression, suicide risk, dementia; Ontario Alzheimer's strategy.
China	A pilot program to transfer psychiatric services from hospital to the community started in 2005.
Hong Kong	Guardianship Board. "Elderly Suicide Prevention Project" 7 teams for detection and treatment of elderly with depression and suicide and training of GPs and other health care professionals.
Ireland	Mental health legislation; enduring power of attorney.
New Zealand	Mental Health Act (1992) and Protection of Personal Property and Rights Act (1989). Positive Ageing Strategy; Guidelines for Dementia, The Health of Older People Strategy, Assessment Guidelines for Older People, Framework for Services for Older People in New Zealand; comprehensive community assessment services, inpatient/outpatient/memory clinics/delirium services; flying doctor services; aging in place initiatives (coordinators of services to the elderly (COSE); promoting independence program, Community First program); and ongoing research and service delivery evaluation.
Romania	Mental Health Law 2001; mental health centers.
U.K.	Best Interest Guidance for people who are unable to give informed consent; national service framework.

partnership with IPA to achieve common goals (Table 2). In this way, IPA has developed remarkable reach in the world since its inception, with members from over 60 countries, and 19 formally affiliated national psychogeriatric organizations (Table 3). The growing and strong affiliations of national organizations with IPA create a strong international lobby which, if crafted wisely, will be a potent instrument of change on behalf of the rapidly growing world population of elders. Each country has produced its psychogeriatric champions,

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Table 2. National organizations: a sample from a selected countries

COUNTRY	ORGANIZATIONS
Argentina	Psychogeriatric section of Argentine Association of Psychiatry (AAP) (∗ medical); Psychogeriatric Forum Intersociety (∗ medical) (Argentine Geriatric Society – SAGG, Argentine Association of Psychiatry – AAP, Argentine Society of Neurology – SNA, and Argentine Society of Psychiatry – APA .>30 Societies of Geriatric Medicine or Gerontology distributed around the country.
Australia	The Faculty of Psychiatry of Old Age (FPOA) (branches in all eight states and territories); The Australian and New Zealand Society of Geriatric Medicine; Australian Association of Gerontology (∗)
Brazil	Section of Geriatric Psychiatry at the Brazilian Association of Psychiatry (BAP); Brazilian Association of NeuroPsychogeriatrics (BANPG)
Canada	Canadian Academy of Geriatric Psychiatry (CAGP), Gerontological Association (CGA), Psychiatric Association Geriatric section (CPA), Coalition for Seniors Mental Health (CCSMH)
China	National: Chinese Society of Psychiatry (∗), Chinese Psychiatrist Association (∗), Chinese Society of Neuropsychiatry, (CSNP) Chinese Psychogeriatric Interest Group (CPIG)
France	French Society of Geropsychiatry
Hong Kong	Hong Kong Psychogeriatric Association (HKPGA) (∗)
Ireland	Irish College of Psychiatrists; Irish Association of Consultants in Psychiatry of Old Age; Irish Gerontological Society (∗); Alzheimer Society of Ireland (∗); Western Alzheimer Foundation (∗); National Council on Ageing and Older People (∗); National Carer's Association (∗)
New Zealand	New Zealand Psychiatrists of Old Age; NZ Psychologists for Older People (NZPOPS;) National New Zealand Gerontological Society (∗); New Zealand Alzheimer's Association
Nigeria	Geriatric psychiatric section of the Association of Psychiatrist in Nigeria; Alzheimer's Disease International (ADI) Nigerian Branch; African Regional Initiative of IPA; Africa Gerontological Society (AGES) (Nigerian Branch) (∗)
Romania	Romanian Association of Psychiatry (ARP); Association of Gerontopsychiatry (ARG) (∗); Alzheimer Society – SRA (∗); Medical Society of Research of Cognitive Disorders and AD; Mental Health League; Psychotherapy Association; Association of Cognitive Psychotherapy
U.K.	National Health Service recently established clinical research networks (mental health; neurology) (∗)
U.S.A.	American: Association of Geriatric Psychiatry (AAGP), American Gerontological Society (AGS) (∗), American Psychiatric Association Council on Aging (APA)

Note: (∗) = multidisciplinary

many of whom have been (or still are) not only national but world leaders in the field. Table 4 is just a sampling of leaders from a small number of countries.

Long-established psychogeriatric and gerontological societies have continued to lead in the U.K. and the U.S.A. Although Australia and New Zealand

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Table 3. IPA affiliated organizations

Australia & New Zealand	Royal Australian and New Zealand College of Psychiatrists – Faculty of Psychiatry of Old Age
Brazil	Brazilian Association of Geriatric Neuropsychiatry
Canada	Canadian Association of Geriatric Psychiatry
China	Chinese Society for Psychiatry – Psychogeriatric Interest Group
Hong Kong	Hong Kong Psychogeriatric Association
India	Indian Association for Geriatric Mental Health
Indonesia	Asosiasi Psikogeriatri Indonesia Association
Israel	Israeli Association for Old-Age Psychiatry
Italy	Associazone Italiana di Psicogeriatria
Japan	Japan Psychogeriatric Society
Korea	Korean Geriatric Society
	Korean Association for Geriatric Psychiatrists
Latvia	Latvian Psychiatrists' Association
Poland	Psychogeriatric and Alzheimer's Disease Section of the Polish Psychiatric Association
	Polish Association of Geriatric Psychiatry
Portugal	Associação Portuguesa De Gerontopsiquiatria
	Associação Portuguesa de Psicogerontologia
Spain	Sociedad Española de Gerontopsiquiatria y Psicogeriatria

are separated by about 1000 miles of ocean they share a common college of psychiatry. Australia has a long tradition of leadership in psychogeriatrics with very well-established organizations for psychogeriatrics, and New Zealand, a country with a population of just 4 million, similarly has developed an impressive network of well-organized and vigorous organizations that address psychogeriatrics. More recently, China has begun actively to address the mental health of elders with vigorous organizational development. Of particular note is the establishment of the very active multidisciplinary Hong Kong Psychogeriatric Association (HKPGA) in 1998. Several organizations in South America address issues relevant to psychogeriatrics in Brazil and Argentina. The Brazilian Association of NeuroPsychogeriatrics is a unique organization that formally integrates geriatric medicine, neurology and psychiatry. However, here as elsewhere, challenges to organizational development continue. For example, the Argentine Society of Geriatric Psychiatry has faltered and is now described as "out of order" for the time being, which is most unfortunate in a country so clearly concerned about the mental health of elders. Canada, with roughly the same population as Australia, established the 200-member Canadian Academy of Geriatric Psychiatry (CAGP) in 1991 along with other strong multidisciplinary groups. The relatively newly formed Canadian Coalition for Seniors' Mental Health is a notable achievement lead by CAGP, unifying about 50 national organizations in the common cause of seniors' mental health. Romania, reflecting strong general interest in psychogeriatrics in Eastern Europe, boasts several organizations with strong affiliations with the European Association of Geriatric Psychiatry and many notable achievements. France established a national

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Table 4. National leaders in psychogeriatrics: a sample from the survey

COUNTRY	LEADERS
Argentina	**Carlos A Mangone**: behavioral neurologist (Buenos Aires), former IPA director, contributor to foundation of National Alzheimer's Associations, Alzheimer's Disease International, the International Working Group for the Harmonization of Dementia Drug Guidelines; **Fernando E. Taragano**: geriatric psychiatrist (Buenos Aires), founder and coordinator of the Psychogeriatric Section of AAP education for general practitioners and research on depression and dementia; **Sergio Starkstein**: neurologist (Buenos Aires); **Ricardo F. Allegri**: behavioral neurologist (Buenos Aires), director of IPA, developed dementia programs in South America. Member IPA Latin American Initiative, the IPA Learning Portal and regional integration of epidemiological, educational, and trans-cultural projects in the world.
Australia	The following are all influential in teaching, research, writing, advocacy, and leadership in IPA: **Edmund Chiu**: professor, University of Melbourne (recently retired), founder of Faculty of Psychiatry of Old Age (FPOA); **John Snowdon**: professor, University of Sydney; founder of FPOA. **David Ames**: professor, University of Melbourne; **Henry Brodaty**: professor, University of New South Wales.
Brazil	**Jerson Laks**: president, Section of Geriatric Psychiatry at the Brazilian Association of Psychiatry, professor of psychiatry at Universidade do Estado do Rio de Janeiro, main author of research in the field in Brazil; **Cassio Machado de Campos Bottino**, head of the Program for Aged People at the Department of Psychiatry, Institute of Psychiatry, Universidade do São Paulo, researcher. **Almir Tavares**, professor of psychiatry at Universidade Federal de Minas Gerais, author of the main Brazilian psychiatry text.
Canada	**Imre Fejer**: co-founder Psychogeriatrics International; **V.A. Kral**: psychogeriatric pioneer; CAGP awards for outstanding contributions to Canadian psychiatry; **David Conn**: assoc. professor; **J. Kenneth Le Clair**: professor of psychiatry, founder of CAGP; **Joel Sadavoy**: professor of psychiatry, founder CAGP; **Kenneth Shulman:** professor of psychiatry. Other key leaders: **Martin Cole**: professor of psychiatry, psychogeriatric pioneer; **Marie France Tourigny-Rivard**: professor, founder CAGP; **Martin Rotenberg**: psychogeriatric teacher; **Blossom Wigdor**; **Gloria Guttman:** professor, gerontology.
France	**J. M. Leger**: professor, psychiatry (retired); **G. Darcourt**: professor, psychiatry (retired); **P. H. Robert**: professor, psychiatry
Ireland	**Brian Lawlor**: consultant psychiatrist/academic, development of clinical and academic psychiatry of old age; **Margo Wrigley**: consultant psychiatrist, development of clinical psychiatry of old age; **Davis Coakley**: professor of geriatric medicine, development of clinical & research gerontology.
New Zealand	**Kingsley Mortimer** OBE: inspirational advocate for older people; **Pam Melding** ONZM: binational chair of the RANZCP Faculty of Psychiatry of Old Age 2001–5, director of IPA; Geriatrician leaders: **John Campbell, Richard Sainsbury, David Richmond**; Gerontology leaders: **Margaret Guthrie** CNZM: assoc professor, **Naire Kerse**, **Mathew Parsons**, **Michal Boyd** (nursing), **Barbara Simons, John Strachan, Annalise Seifert, Chris Collins, Ken Fox, Crawford Duncan, Chris Perkins**

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Table 4. Continued

COUNTRY	LEADERS
Nigeria	**Olusegun Baiyewu**: professor of psychiatry; director IPA, associate editor *International Psychogeriatrics*; **Richard Uwakwe**: senior lecturer/ consultant psychiatrist, country coordinator of ADI; **Adesola Ogunniyi**: professor of neurology; **Oye Gureje**: professor of psychiatry; **Felix Potonick**: psychiatrist
PRC China	**Zhang Mingyuan**: past president of CSP, leading policy-maker in mental health; **Zhou Dongfeng**: current president of CSP, leading psychiatric opinion leader
Romania	**Nicoleta Tataru**: founding president of the Romanian Association of Gerontopsychiatry and "Worrying about Grandparents"; **Catalina Tudose**: founding president of the Romanian AD Society and Romanian Mental Health League, Romanian Medical Society of Research of Cognitive Disorders and AD; **Virgil Enatescu**: founding president of the Romanian Association of Cognitive Psychotherapy.

psychogeriatric program but psychogeriatrics has only recently begun to be recognized as a special focus. In Ireland, growth of both the discipline of psychogeriatrics and related national organizations for both professionals and carers has been strong.

Overall, the numbers of practitioners of psychogeriatrics in most countries has been very strong over the past 25 years especially in countries which now have a very well established psychogeriatric infrastructure such as the U.K., U.S.A., Australia, Canada, New Zealand, Brazil, Ireland, Sweden and others. In countries with newer psychogeriatric organizations expansion continues. However, while growth was strong in earlier years it is of some concern that it may have plateaued in some leading countries and may actually be declining in some regions. This may be reflected in the changing pattern of membership of IPA with increasing strength emerging in developing regions and Asia while European and North American membership seems to have flattened out for the time being. Advanced training is widely available in many countries but recruitment of talented trainees to these programs is sometimes surprisingly difficult considering the undisputed immense needs in this area of study and practice. If recruitment within medical psychogeriatrics is less than vigorous one possible reason may be the lack of attention paid to training at the earliest stages of medical education in medical schools, together with relatively weaker financial incentives for psychogeriatrics in some countries such as the U.S.A. Of the countries surveyed, most reported variable or no psychogeriatric training in medical schools. Based on experience and some data (Herrmann *et al.*, 1992) the most effective recruitment occurs when medical students are exposed early in their training. This suggests that more effort needs to be put into introducing medical students to inspiring psychogeriatric teachers and adding geriatric psychiatry to the basic medical school curriculum. Once trainees enter psychiatric residency it is sometimes too late to motivate interest in the elderly.

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Throughout its history, IPA counted among its membership many if not most of the world's leaders in psychogeriatric education, positioning the organization to assist programs throughout the world to develop psychogeriatric curricula and promote the education of practitioners. Indeed, in various group interviews about priorities for IPA conducted at the 13th IPA world congress in Stockholm, Asian leaders placed curriculum development near the top of their list of priority needs.

To begin to address this need IPA has convened an international symposium on psychogeriatric curriculum development to be held at the 2007 IPA Silver Congress in Osaka with the goal of establishing a plan and a network of educators to address this crucial issue. The task of educators is stimulating because educational programs cannot be universal and require tailored curricula of study. For example, consider what one should teach practitioners about dementia care if case identification is poor, expensive neuroimaging and medications are inaccessible, community care is minimal or long-term care services virtually non-existent. Or contrast the differences in educational programs that we might need for treating the familiar needs of elders in many developed countries with the needs of elders in most of Africa. At a 2000 conference on aging in Africa in Harare, Zimbabwe, the World Health Organization (WHO) correctly emphasized the plight of elders whose expected social support network in old age has been devastated by the displacement of war, the calamity of famine and of course the unprecedented deaths among young and middle-aged parents caused by the modern plague of HIV/AIDS (WHO, 2000). Grandparental elders in Africa are all too often significantly impacted by the loss of the support of their children who have died of AIDS as well as by the unexpected role of substitute parent suddenly thrust upon them at a time in their lives when they are least prepared to take on these new roles.

While the educational challenges are great, considerable resources exist since most countries have well-established or strong growth in training programs. Table 5 summarizes some information on training resources in several countries.

With strong growth in education in so many countries IPA has the opportunity to assist educators and scientists by coordinating the dissemination of the highest quality of scientific knowledge. There are many ways to do this. At an individual level, IPA leaders such as Drs. Edmund Chiu and David Ames of Australia have created and delivered basic and advanced courses. Organizationally, IPA has delivered its educational programs largely through its many consensus, regional and world congresses and through its excellent journal *International Psychogeriatrics* and the *IPA Bulletin*. But we are also keenly aware of the importance of ensuring that education is easily accessible. At present there is a wide gap between what we know and getting this information to practitioners in such a way as to influence the majority of treaters such as the primary care practitioners (who, according to the WHO, offer the best model of service delivery). A successful future will require a concerted effort to download scientific knowledge to the bedside.

Making knowledge and educational opportunities accessible poses yet more challenges, not least the substantial difficulties that many members of the psychogeriatric profession experience in getting to IPA meetings. We live

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Table 5. Psychogeriatric training institutions: a sample from selected countries

COUNTRY	LOCATION OF TRAINING
Argentina	Postgraduate training in four centers (Maimonides, ISalud, Favaloro, Sociedad Argentina de Geriatria y Gerontologia); focus on dementia and depression
Australia	More than 20 comprehensive programs in public aged psychiatry services, mostly in major metropolitan areas and larger private psychiatric facilities
Brazil	At least five multidisicplinary programs in psychogeriatrics; MSc and PhD training in at least five departments of psychiatry in federal universities
Canada	Comprehensive training now available in all medical schools; advanced psychiatry training programs in most provinces. Training strength in nursing, social work, psychology, gerontology
China	15 new training programs developed in the past 25 years at major university teaching hospitals; Advanced training programs in Shanghai and Beijing; focus on dementia, depression and community care. Hong Kong: Psychogeriatric elements in undergraduate and postgraduate curriculum: 7 psychogeriatric teams train psychiatrists
France	Five new training programs
Ireland	Each of 25 consultant-led teams provides 1–2 six-month trainee psychiatrist positions. One national higher specialist program
New Zealand	Three psychiatric and other nursing programs developed in past 25 years with advanced psychiatry training in Auckland and Christchurch. Primary care geriatric/psychogeriatric program at the University of Auckland
Romania	Seven training programs in Oradea, 14 in Bucharest. One-year specialist courses and GP training in Bucharest
U.K.	Many pioneering and distinguished model faculties and educational leaders
U.S.A.	Many pioneering and distinguished model faculties and educational leaders

in an age when travel has become not only expensive but complicated by travel restrictions based on the safety or political concerns of many countries. Recognition of these problems led IPA to begin to create more advanced approaches to delivering education, including enhanced use of technology. The initial step was using technologies to create the IPA Learning Portal with the goal of establishing an accessible electronic information resource for members and other professionals. The IPA Learning Portal contains the early phases of a Psychogeriatric Knowledge Bank containing a growing archive of the remarkable academic richness captured at IPA meetings. The outreach philosophy of the Learning Portal led IPA in 2006 to transmit its first multinational live interactive educational program broadcast in real time to over 400 delegates in five countries. Decentralizing educational programs is another outreach strategy. Hence, in the fall of 2007, IPA will launch the first of a proposed series of seminars that can move from city to city to educate practitioners on neuroimaging.

Psychogeriatric care requires coordinated systems that are accessible, acceptable and effective. Such systems cannot come out of scientific advances

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alone but must be married to the political will to create a vision and bear the expense of implementation. This vision includes coordination of social, environmental and medical interventions with philosophies of care appropriate to the elderly. An international forum such as that offered by IPA becomes an ideal place to foster creativity of thought and exchange of ideas, a place where we can disentangle those elements of care which are essential to all models of service from those which are culturally or environmentally unique to a given region.

To communicate complex ideas the members of the international psychogeriatric community need to understand one another. Here language is a major issue. IPA has adopted a common language, English, to do its business but this poses real barriers to both information and colleagueship for many, especially those in the non-medical allied professions. IPA has struggled with how to avoid the unintended imperialism of language, for example, by offering translation as much as possible in the local language at meetings and at breakout sessions. But inevitably the degree of common understanding suffers. Many of the more sophisticated concepts that make up the heart of psychogeriatric practice in many locations is blanketed in the fog of poor communication among professionals. Sometimes this means that the easier-to-convey ideas become the focus. The language of technology and empirical science seem to be more readily understood among international professionals while the nuances of emotion, motivation, need, psychological conflict and interaction are more confounded by language issues. This communication gap together with the natural excitement and emphasis of the past two decades on our successes and hopes in neuroscience, imaging and psychoneuropharmacology has sometimes left behind the study and dissemination of the more difficult to study areas of human interaction, social change and public policy.

Addressing mental disorders of the elderly will require strong leadership and a unified professional stance to create new knowledge through research, dissemination through education, and advocacy to promote public policy and systems of service delivery. IPA enters the next quarter century with the will and vigor to work to ensure better mental health for elders throughout the world.

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I thank each of the IPA leaders who responded to the survey prepared for this editorial and contributed to the country specific information. I realize there are inevitable gaps in the information for which I take responsibility and which perhaps can be gradually filled in over time. I also want to thank the IPA secretariat for its help in revising and disseminating the survey.

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