Objective: The objective of this study is to describe the diagnostic agreement between physicians and liaison psychiatry units (LPU) in 7 general hospitals of Spain for elderly patients and to analyze possible factors related to it.

Methods: This is an observational., cross-sectional, multicenter study. We obtained data from a sample of 165 patients (≥65 years) admitted to 7 general hospitals in Spain referred from different departments to each liaison psychiatry unit. Data was collected for a month and a half period. Psychiatric evaluations were performed while the patients were on wards.

Results: We obtained a sample of 165 patients (78 women, 88 men) with a mean age of 76,03 years old (42.10% <75 years, 57,83% ≥ 75 years). Most of them were married and they lived accompanied (67,27%). Only 5,45% lived in a nursing home.

In 55.15% the main reason to referral was anxiety/depression symptoms. 42,42% had no psychiatry medical background. After LPU visit a new diagnosis was done in 56.96%. Main diagnoses were adjustments disorders (26,66%), delirium (20,6%) and no psychiatric pathology (14,54%)

Cohen's kappa statistics were used to estimate the agreement between the diagnoses made by LPU and the diagnoses considered by the referring doctors. We obtained a moderate global agreement (kappa= 0,4971) between observers (0,424 for <75 years, 0,557 for ≥65 years) Moderate agreement was found for alcohol or substance abuse (kappa= 0,41) and low agreement was found for affective disorders (kappa= 0,3278) and delirium/ psychological and behavioral symptoms in dementia (Kappa= 0,2341).

We analyzed factors which might affect de agreement between physicians and LPU such is group of age, functional impairment, comorbidity by Charlson index and previous diagnosis of dementia.

Conclusions: Further longitudinal studies might help in the future to analyze the factors related to agreement between doctors and might help to establish educational programs

P120: Peer groups that support the mental health of older adults

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The City of Helsinki provides peer support groups for older adults with substance abuse or mental health issues:

- For older adults with substance abuse issues (14 meetings)
- For elderly relatives, friends and family members of people with substance abuse issues (12 meetings)
- For older adults with depression symptoms (12 meetings)
- For older adults who have lost a loved one (8 meetings)

Peer support groups meet once a week at senior centres and are led by social instructors. The maximum group size is limited to ten people. Group instructors have manuals to guide their work, and attendees follow group-specific assignment books. The first three groups listed above stem from cognitive methods, and the group for those who have lost a loved one stems from a meaning-centred approach.

Before the group's first get-together, instructors meet all potential group members in person to ensure that joining the activity is a suitable and beneficial option for them. Although the groups have different discussion topics and assignments, all are primarily based on openness and peer support. Two months after the group's last get-together, members will meet up again, and the instructors will assess whether someone needs extra support and refer them onward.

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Overall, feedback on the peer support groups has been positive. Attendees feel participating has brought change to their lives, and many reported reduced alcohol consumption and improved mood. In their feedback, attendees gave thanks to interesting discussion themes, an open and trusting atmosphere and the importance of being able to communicate with peers of the same age.

Peer support groups are a cost-effective and functional way to support the mental health of older adults, especially in the early detection and prevention of more severe problems.

P127 Characteristics and outcomes of geriatric patients with depression who received pharmacogenomic testing for antidepressant medication selection

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Objective: Pharmacogenomic testing for antidepressant medication selection is widely available, and patients with treatment-resistant depression regularly inquire about it. Psychiatrists and primary care providers have little guidance on when to obtain pharmacogenomic testing. We reviewed the characteristics and outcomes of a sample of geriatric patients who received this testing.

Methods: Retrospective review of patients ages 65 and older with ICD-10 diagnoses of depressive disorders (F32.0-F33.9), followed at Mayo Clinic Rochester, who received pharmacogenomic testing between 1/1/2018 and 12/31/2022 to guide antidepressant medication selection. Patients were included if there were Patient Health Questionnaire 9-item (PHQ-9) depression rating scores up to 3 months before and 3 months after pharmacogenomic testing. Demographic information, cytochrome P-450 CYP2D6 and CYP2C19 phenotypes, PHQ-9 scores, ordering provider (psychiatrist or primary care provider), and resulting medication changes were collected. Paired t-tests compared differences between before and after PHQ-9, with statistical significance $p<0.05$.

Results: Approximately 1% of patients with a depressive disorder received pharmacogenomic testing. After limiting to patients with PHQ-9 before and after testing, 287 patients met inclusion criteria. 66% were female, mean age 72.3 yrs ($\pm$SD 5.7, range 65.0-90.7), and 95% were Caucasian. CYP2D6 phenotypes were 9% poor, 48% intermediate, 39% extensive (normal), 3% rapid metabolizer. CYP2C19 phenotypes were 3% poor, 25% intermediate, 39% extensive, 33% rapid metabolizer. Mean PHQ-9 before testing was 10.8 ($\pm$SD 6.4), and after testing was 9.8 ($\pm$SD 6.5) ($p=0.0041$). Data collection regarding ordering provider and medication changes were still pending.

Conclusion: The clinical utilization of pharmacogenomic testing appeared to be low. CYP2D6 and CYP2C19 phenotypes were as expected (except for more 2C19 rapid metabolizers), suggesting treatment resistance was less likely related to these genetic factors. There was a statistically significant decrease of 1 point in the mean PHQ-9, which would not be clinically significant. However, many other factors still need to be explored, such as details about medications and gene-medication interactions, ordering provider's knowledge about pharmacogenomic testing, whether medication changes were made, aging factors influencing pharmacokinetics, medical and psychosocial burdens, and other concurrent treatments. Further research will hopefully allow more practical guidance on whether and when to obtain pharmacogenomic testing.

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