the peripheral procholinergic side effects of xanomeline, providing a strategy for using xanomeline to stimulate brain muscarinic receptors with a decreased side effect burden. Unlike available antipsychotics, xanomeline and trospium have no direct dopamine D2-blocking activity, and as such, its safety and tolerability profile is different.

Methods: The phase 3 ADEPT-1 trial is a double-blind, flexible-dose, placebo-controlled randomized withdrawal study to evaluate the safety and efficacy of xanomeline and trospium in decreasing the risk of relapse in subjects with ADP. Subjects aged 55-90 years with moderate to severe psychosis associated with mild to severe AD (Mini-Mental State Exam score range 8-22) will be enrolled into the study. Subjects will receive single-blind xanomeline and trospium for 12 weeks. Each subject will be flexibly titrated to the maximum dose of xanomeline and trospium 200 mg xanomeline/20 mg trospium/day. At the end of the single-blind treatment, eligible responders will be randomized to either continue xanomeline and trospium or be switched to matched placebo for a 26-week double-blind treatment period. A responder is defined as a subject with a ≥40% decrease (improvement) on the Neuropsychiatric Inventory- Clinician: Hallucinations + Delusions (NPI-C: H+D) score compared with baseline (day 1) and a Clinician Global Impression–Change (CGI-C) score of 1 or 2 (very much improved or improved).

Results: The primary endpoint of the study, time from randomization to relapse during the double-blind, randomized withdrawal treatment, will be evaluated by survival analysis using Kaplan-Meier Methods. The study started in August 2022 and will randomize approximately 200 subjects.

Conclusions: The trial design of the ADEPT-1 study is an efficient way to assess the potential for xanomeline and trospium to provide clinically meaningful benefit in preventing the return of ADP in patients who have responded to xanomeline and trospium.

P21: Buddhist temples are promising social resource in secular community-based integrated care (2): Peer support, spiritual care, and grief care for caregivers at the Buddhist temples caregiver cafés

Authors: Chiaki Ura, Tsuyoshi Okamura, Akinori Takase, Yukan Ogawa, Ryosho Shoji

Objectives: In an era marked by a 100-year life expectancy, nearly everyone may eventually become a caregiver to a family member or someone close, yet caregiver support remains insufficient in Japan. Outside the government's comprehensive community-based integrated care system, Buddhist temples are notable for supporting caregivers of individuals with dementia at home. To evaluate the rationale, feasibility, strengths, and fairness of using temples as a community resource within a community-based integrated care system, it is crucial to critically analyze views from secular healthcare professionals familiar with these activities. This study aims to explore the characteristics and potential of caregiver cafés hosted in Buddhist temples from the perspective of staff members involved in secular community- based integrated care system.

Methods: Initially, a preliminary questionnaire survey was administered to 13 priests at Jodo Shu temples that host caregiver cafés to ascertain the current status of these cafés and explore potential collaboration routes with public organizations for future research. Subsequently, semi-structured interviews were conducted with 15 staff members from public organizations involved in community-based integrated care, such as community-based integrated support centers, social welfare councils, and NPOs, who participate in caregiver cafés at Buddhist temples.

Results: All temples were found to cooperate with public institutions involved in community- integrated care. Thematic analysis led to the identification of 20 subcategories from 150 discourses. These subcategories, which had similar content, were further consolidated into a single category and ultimately grouped into four major

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categories: temples as social resources, temples and priests leveraging their strengths, familiar temples open to the community, and fair temples.

Conclusions: The findings suggested that temples have significant potential to integrate into community-based care systems and play crucial roles in supporting Japan's super-aged society.

P22: Treatment-resistant depression and risks of suicide and natural mortality in Taiwanese elderly patients with major depressive disorder

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Objectives: Depression is the second most prevalent mental illness among the elderly. Nonetheless, treatment-resistant depression (TRD) is prevalent among the elderly; one-third of elderly patients with major depressive disorder (MDD) who received antidepressant treatment failed to achieve remission. Although there have been several studies regarding the associations between MDD and increased mortality and suicidal risk, studies between TRD and mortality/suicidal risk in the elderly still remains limited. In this national cohort study, we examined the association between TRD, non-TRD MDD, and non-depression with all-cause mortality, accident mortality, and suicide mortality.

Methods: For this retrospective longitudinal analysis on the entire population, the National Health Insurance Research Database of Taiwan, which comprises claims data from a lifetime insurance program and provided comprehensive medical inpatient and outpatient information categorized by ICD-9-CM and ICD-10. The National Mortality Registry offered information regarding mortality resulting from all causes, natural causes, suicide, and accidents. A cohort of ≥60-year-old patients, including both those with and without MDD, was observed between January 2003 and December 2017. Individuals were classified as TRD if they had undergone aminimum of two distinct antidepressant trials within the current episode's two-year duration and dose, as documented in the prescribing records. Adjusted hazard ratios (aHRs) and 95% confidence intervals (CIs) were calculated for mortality risk utilizing Cox regression models.

Results: Among those >60 years old, after adjusting with sex and comorbidities, TRD was associated with increased risk of suicide (aHR 7.4, 95% CI [5.6-9.8]; MDD without TRD 4.4 [4.1- 4.6], compared with non-MDD group). Simliar risk of accident mortality was observed among three groups (TRD aHR 1.3 [0.9-1.9]; MDD without TRD 0.9 [0.9-1.0], compared with non-MDD group). Surprisely, TRD might presented lower mortality risk of natural mortality than the non- MDD group (TRD aHR 0.8 [0.7-0.8]; MDD without TRD 0.9 [0.8-0.9], compared with non-MDD group).

Conclusions: The suicide mortality among elderly patients with TRD is higher in comparison to non-MDD patients; nevertheless, accident mortality does not appear to have increased and the natural mortality rate is reduced. The lower mortality may reflect patient selection, and the contributing factors need further evaluation.

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