The scope of practice requires an understanding that elderly patients have a complex interplay of structural and neurochemical brain changes, physiological and immunological reactions, personality structure, stressful life events, and early psychological development. Most have multiple chronic and concurrent medical and psychiatric conditions, and the Geriatric Psychiatrist must be adept at managing both. Further complexity is created by a variety of contextual issues including family dynamic issues, exhausted caregivers, and stigma of old age and mental illness.

Management plans often necessitate multiple strategies. In addition to expert use of safe, effective pharmacological treatment options the Geriatric Psychiatrist is expert at psychological and environmental interventions adapted for the elderly. Caregiver support interventions are often crucial for success. The delivery of ECT for the treatment of depression in those frail elderly patients not responsive to, or unable to tolerate pharmacological interventions, is unique to geriatric psychiatry. The management plan is communicated and managed in collaboration with multiple disciplines.

Geriatric Psychiatrists are frequently required to work outside traditional hospital settings. Because of the nature of the illnesses described, the patient is best served in their place of residence. Elderly Canadians increasingly require care in their own homes, yet comprehensive outreach services that ensure older persons' access to subspecialty-level care are seldom provided by disciplines outside geriatric psychiatry.

Training Requirements & Length of Training

A subspecialty resident in geriatric psychiatry will complete a total of two years of dedicated training in preparation for a career as a leader in geriatric psychiatry. To attain the required level of subspecialty expertise, not only in terms of medical expert skills, but also in each of the other CanMEDS competencies, particularly Collaborator, Scholar, Manager and Health Advocate, requires at least two years of dedicated training.

Up to 12 months of the two year training, if completed during fulfillment of the primary certification requirements in psychiatry, may be credited toward subspecialty training with approval from the Subspecialty Program Director. The 6-month mandatory core experience in geriatric psychiatry completed during psychiatry training would not be eligible for credit, as it is structured to develop foundational skills rather than subspecialty expertise.

For more information visit: *www.cagp.ca*

CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY
55 St. Clair Avenue West, Suite 255 | Toronto, ON M4V 2Y7
416.921.5443 | 1.877.330.5443
info@cagp.ca | *www.cagp.ca*

Canadian Academy of Geriatric Psychiatry
CAGP

L'Académie canadienne de psychiatrie geriatrique
ACPG

What is a Geriatric Psychiatrist?

What is a Geriatric Psychiatrist?

Geriatric psychiatry, a psychiatric subspecialty, focuses on the assessment, diagnosis and treatment of complex mental disorders occurring in late life. It is focused on providing care at the end of the life cycle, a time when many complex physical and mental health issues coalesce. The subspecialty generates new knowledge through research, and interprets and disseminates new knowledge and best practices in geriatric psychiatry. Geriatric psychiatry organizes delivery of psychiatric care to the elderly in multidisciplinary teams and in locations that best serve this elderly population.

Scope of practice and primary diseases seen

The etiology and expression of disease and the response to treatment options for mental illness in the elderly is very different than for the younger adult population with mental illness. Primary disease entities and symptom presentations unique to the practice geriatric psychiatry include those diseases indicative of some degree of "brain failure."

Those diseases include:

- Late-onset Depression, differs markedly from early onset depression. It is associated with structural brain changes on CT and MRI and profound functional decline for the patient. It is often colored by somatic pre-occupation or somatic delusions, which are mistaken for medical conditions. Elderly patients with medical problems and depression have twice the length of hospital stay compared to those who are not depressed.
- Behavioral and Psychological Symptoms of Dementia (BPSD), defined as "symptoms of disturbed perception, thought content, mood or behavior occurring in persons with dementia." It includes verbal and physical aggression, agitation, paranoia, wandering, persistent vocalizing, and depression. It occurs in 90% of persons during the course of dementia and is the most frequent reason for long-term care placement or chronic hospitalization. Management of moderate and severe BPSD is the unique niche of geriatric psychiatrists.
- Primary dementias presenting with prominent, early psychiatric symptoms, often without obvious memory impairment, such as vivid visual hallucinations in Lewy Body Dementia, personality changes in Fronto-temporal Dementia, and apathy and executive dysfunction in Vascular Dementia.
- Complex presentations of Delirium, with psychosis, behaviour disturbances, and catatonia. An episode of delirium in older adults carries a 2-3 fold relative risk increase for functional impairment, and a 46% institutionalization rate post-hip fracture.
- Psychiatric complications of Cerebrovascular Accidents (CVA's). Post-stroke incidence of depression is very high (41% in first year post-stroke). Presence of untreated depression results in failure to successfully rehabilitate, and results in prolonged hospital stays and more frequent placement in Long Term Care.
- Psychiatric complications of neurodegenerative disorders such as Parkinson's Disease, and Huntington's Disease.

In addition to these unique diseases, the Geriatric Psychiatrist is consulted in situations of atypical or unrecognized presentations, or treatment failures, of more common diseases such as:

- Alzheimer Dementia, especially when presenting in those less than 65 years of age.
- Treatment-resistant Depression.
- Bipolar disorder, either late onset or with treatment complications due to aging and/or co-morbid medical conditions.
- Schizophrenia with complications related to aging.
- Developmental Delay, with complications related to aging, including dementia. Most individuals with Down's Syndrome develop Alzheimer Disease in their fifth decade.
- Substance Abuse, usually alcohol and benzodiazepines.

Unique situations that are not disease specific, but require the expertise of the Geriatric Psychiatrist, include:

- Complex capacity/competency assessments in frail elderly/dementia patients for decisions regarding medical treatment, finances, personal care/living independently, choosing a power of attorney, operating a motor vehicle.
- Poly-pharmacy and related side effects and drug-drug interactions. At times this situation mimics a psychiatric condition.
- Psychotropic medication use (eg. Risk assessment regarding use of atypical antipsychotics in the elderly when Health Canada and the FDA have issued warnings about their use in this population).
- ECT use in frail/demented elderly patients.