



CAGP

Bulletin

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Editorial

CAGP Bulletin Guidelines for Editorial and Advertising Pages

LONN MYRONUK

The issue of paid advertising and sponsorship in professional and academic publications is complex. A publication can only be successful if its readers trust the information or advice given. The reader must be able to discern which content is educational, and which content is promotional.

Prior to considering any paid advertisement for inclusion in the Bulletin, we propose that the Academy adopt the following editorial guidelines, which have been derived from those promulgated by the American Society of Magazine Publishers¹.

1. LAYOUT AND DESIGN

The layout, design and typeface of advertising pages will be distinctly different from the publication's normal layout, design and typefaces. Any page of advertising that contains text or design elements that have an editorial appearance will be clearly and conspicuously identified with the words "advertising," "advertisement" or "promotion" horizontally at or near the center of the top of the page in type at least equal in size and weight to the Bulletin's normal editorial body type face.

2. USE OF THE ACADEMY'S LOGO, ETC.

At no time will the Academy's or Bulletin's name, logo or editorial staff be used in a way that suggests editorial endorsement of any advertiser. Specifically:

- (a) No advertisement may be promoted on the cover of the Bulletin or included in the editorial table of contents. This includes cover stickers and other onsets.
- (b) In general, the Academy's name or logo will not appear on any advertising pages except when advertising the Academy's own activities and services.

From the Vancouver Island Health Authority, Nanaimo, BC.

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Advertising pages will not be placed adjacent to related editorial material in a manner that implies editorial endorsement of the advertised product or services. No advertising copy should state or imply advertiser control or improper involvement in the preparation of editorial materials in an issue. Similarly, an advertiser's name or logo may not be used on any editorial pages to suggest advertising sponsorship of those pages, nor will any editorial page be labeled as "sponsored" or "brought to you" by an advertiser.

4. EDITORIAL REVIEW OF AD PAGES

In order for the Bulletin's chief editor to have the opportunity to monitor compliance with the guidelines, advertising pages must be made available to the editor in ample time for review and to recommend any necessary changes.

Similar standards have been developed for web pages on the Internet². These additionally address the issue of hyperlinks between editorial and promotional content. We propose that those extended standards be adopted for the Academy's web sites, and that the guidelines themselves be available for users to access through our sites.

The Bulletin welcomes your opinions on this, or any other matter. When writing to the Editor, please indicate if your correspondence is to be considered for publication.

REFERENCES

1. ASME (1998) Guidelines for Editorial and Advertising Pages. http://asme.magazine.org/guidelines/editorial_and_advertising.html
2. IDG (2002) Editorial guidelines for IDG Web Site: ASME Guidelines with IDG Extensions. <http://www.idg.com.hk/about/asme/>

President's Report

DAVID CONN

The tenth annual meeting of the Academy, which was held in Montreal, was a great success. We had a record number of registrants and were treated to an excellent program. One of the highlights was the session featuring presentations by our 7 Resident Award winners. It is clear that the future of Geriatric Psychiatry in Canada is very bright. I would like to thank Lilian Thorpe, Francois Primeau and Francois Rousseau for their tremendous efforts in organizing the meeting.

At the meeting I had the opportunity to thank the following members who have served on the Board of the Academy over the past 10 years : Femi Agbayewa, Ray Ancill, Martin Cole, Fernande Grondin, Bernard Groulx, Andy Hackett, David Harris, Paule Hottin, Evelyn Keller, Ken Le Clair, Susan Lieff, Isabel Martins, Lonn Myronuk, Anne Potvin, Francois Primeau Marie-France Rivard, Matt Robillard, Francois Rousseau, Joel Sadavoy, Cathy Shea, Ivan Silver, Marlene Smart, Kevin Solomons, Howard Strong and Lilian Thorpe.

The much anticipated National Symposium on "Gaps in Mental Health Services for Seniors in Long-Term Care Facilities" will be held in Toronto on April 28th and 29th 2002. Approximately a hundred representatives from governments, professional associations, advocacy groups and other organizations from across the country will attend. Please see details in this edition of the Bulletin. A Blueprint for Action will be developed and we expect that a National Coalition will be formed during the Symposium. We should feel proud that our Academy has led the way with the initiation and development of this Project. Many thanks to Shelly Haber, who has worked tirelessly to ensure a successful outcome.

Finally I would like to inform you that the date of our next Annual Scientific Meeting has been changed to avoid a conflict with Halloween. The meeting will be held immediately following the CPA meeting on Monday November 4th 2002 in Banff Springs. The theme will be Geriatric Neuropsychiatry. We look forward to seeing you there.

Pharmacologia

Treatment of BPSD: Facts vs Fads

NATHAN HERRMANN

As modern physicians, we pride ourselves in our ability to practice evidence-based medicine (EBM). It is, therefore, somewhat sobering to be reminded that occasionally we are no less susceptible to fads than our fashion design colleagues. Admittedly, this typically occurs where evidence is lacking, but once established, these treatment fads can be harder to vanquish than mini-skirts. One such example, is the management of the behavioural and psychological symptoms of dementia (BPSD). Previously in this column, I have reviewed data on the management of BPSD with anti-epileptic drugs. I noted that despite the relative strength of evidence for use of carbamazepine (three positive RCT's), carbamazepine was given only "modest" support for the treatment of anger and aggression in BPSD by the Expert Consensus Guidelines for the Treatment of Agitation in Older Persons with Dementia (1). This was in contrast to the use of valproate, rated as a "treatment of first choice" for this indication, despite a dearth of evidence (no RCT's). I suppose an argument could be made that clinicians were uncomfortable with the adverse events associated with carbamazepine (confusion, tremor, hepatic dysfunction, hematological toxicity, etc.) and its significant potential for drug interactions. Valproate was, therefore, being used as a safer alternative that had also proven its benefit in younger bipolar patients. Regardless of the rationale (or lack thereof), the use of valproate for BPSD has become quite popular, and it is not uncommon for me to see patients referred by family practitioners who have already been started on valproate for agitation.

This past year, the first two RCT's with valproate were finally published. In a six week RCT with 56 elderly dementia patients in long-term care institutions, Porsteinsson et al. randomized subjects to valproate or placebo (2). Valproate was given as divalproex sodium sprinkles starting with 125 mg t.i.d. and titrated by 125 mg every three days. Average valproate dose was 826 mg per day. There was no significant difference on any of the outcome measures (including two behaviour scales and a global impression) except for one agitation subscale score (and then, only after the magic of statistically adjusting for covariates). Adverse events, however, were significantly higher in the valproate group (68%) compared to the placebo group (33%). In the discussion, the authors work hard to convince readers that these results are positive, though well versed EBM physicians will have already recognized this as a negative study prior to reading their propaganda.

The second study is a much larger multicentre RCT with 172 dementia patients treated with valproate or placebo for six weeks (3). The study was designed to see if valproate could improve the manic-type symptoms of BPSD (e.g. tension, hostility, suspiciousness, uncooperativeness, excitement, etc.). Valproate was administered as divalproex sodium delayed-release tablets starting at 125 mg b.i.d. and increasing by 125 mg per day until reaching a dose of 20 mg per kilogram per day. The average final dose of valproate was 1000 mg per day. On the primary outcome measure (a manic symptom rating scale), there was no difference between valproate and placebo. On a secondary measure of agitation, valproate was significantly better than placebo. Unfortunately, on clinical global impression, placebo was significantly better than valproate. Valproate did not appear to be well tolerated in this study either, with significantly more dropouts (54%) compared to placebo (29%), necessitating an early suspension of the study. Once again, the investigators attempt to put a positive spin on their results, but

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also point out the virtue of using lower daily doses (<15 mg per kilogram per day) and a slower titration schedule.

I suppose two negative RCT's with over 200 subjects should not necessarily lead us to abandon a treatment that has been helpful clinically. It is still possible that valproate might be a useful treatment for patients who have not responded to therapy with an antipsychotic. I should, however, point out one final study that was published this year and addresses clinicians' confidence in valproate's safety. In a chart review of psychiatric inpatients who had been treated with valproate, more than half of the elderly patients (but only 13% of younger patients) experienced at least one episode of thrombocytopenia (4). This prompted the investigators to raise clinical concerns about its use and recommend regular monitoring of platelets especially in the elderly. Perhaps next time, as you reach for your bell-bottom pants or platform shoes, you might ask yourself how much evidence is enough to embrace, or abandon, a popular therapy?

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1. Alexopoulos GS et al (Eds): Treatment of Agitation in Older Persons with Dementia. The Expert Consensus Guidelines Series. Post-Graduate Medicine Special Report, McGraw Hill, 1998.
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4. Tranel TJ et al: Occurrence of thrombocytopenia in psychiatric patients taking valproate. *Am J Psychiatry* 2001; 158:128-130.

Annual Scientific Meeting Proceedings **Geriatric Psychiatry 2001:** **Service Delivery in a Challenging World**

NOVEMBER 15, 2001

Reducing the Burden of Mental Illness in Elderly Populations

Martin G. Cole, MD, FRCPC, St-Mary's Hospital, McGill University, Montreal, Quebec.

Traditional clinical geriatric psychiatry services will not reduce substantially the burden of mental illness in elderly populations for two reasons. First, a relatively small proportion of elderly subjects have contact with these services. Second, traditional services ignore subjects with mental disorders that are subsyndromal but important. Three alternative service models should be explored. These models include: 1. Identification of populations at risk and implementation of populationbased interventions. 2. Identification of individuals at risk and implementation of risk factor abatement programs. 3. Identification of individuals with symptoms/disorders and implementation of treatment programs.

The Millennium Project of the Canadian Academy of Geriatric Psychiatry

David Conn, MD, FRCPC, Baycrest Centre for Geriatric Care, University of Toronto
Ken LeCLAIR, MD, FRCPC, Queen's University, Kingston, Ontario
Shelly Haber, Toronto, Ontario

The overall goal of the project is to "improve the mental health of the elderly in long-term care through education, advocacy and collaboration." The Millennium Project goals are: a) to implement educational initiatives that incorporate "best practices; b) to develop new knowledge in teaching approaches; c) to collaborate with key

National, Provincial and community organizations and policy makers; and d) to increase public awareness and understanding. The CAGP Millennium Project Steering Committee has 11 members representing each region of Canada. The CAGP is partnering with ten other National organizations to plan a National Symposium entitled "Gaps in Mental Health Services for Seniors in Long-Term Care Facilities." The Symposium will take place in Toronto on April 28-29, 2002. The goal of the Symposium is "to engage all relevant stakeholders to discuss issues and identify and implement solutions to improve mental health for seniors living in long-term care settings". The expected deliverables for the Symposiums include a post-conference report, recommendations for short-and long-term initiatives and the development of a national network. The CAGP is attempting to obtain funds to implement postconference initiatives, including an application to the Population Health Initiative, which is funded by health Canada.

Rural Service Delivery Through Teleconferencing

Lonn Myronuk, MD, FRCPC, Central Vancouver Island Health Region, Nanaimo, BC

Telepsychiatry is the use of electronic communications technology to eliminate or reduce geographic barriers to receiving psychiatric services. Video teleconferencing technology is one mean of delivering sub-specialty geriatric psychiatry clinical service to smaller remote communities that are of insufficient size to sustain a sub-specialist in permanent practice. Technical challenges to the implementation of this service have been limited by audio and video fidelity, and transmission time delays. Development of digital signal streams and faster codec processing has addressed these issues. Clinical challenges of patient acceptance and consent, along with physician acceptance and participation have proven to be surmountable in the context of the Tele-Mental Health project through the University of British

Columbia Mental Health Evaluation and Community Consultation Unit (Mheccu). Financial challenges of capital equipment costs, operating expenses, and the development of suitable Fee-for-Service billing codes remain to be addressed before the widespread adoption of video teleconferencing for geriatric telepsychiatry can be expected.

Evaluation of Out-Patient Referrals for Elderly Depressed Patients from the Community

François Primeau, MD, FRCPC and Dominique Proulx, PhD St-Mary's Hospital and McGill University, Montreal, Quebec.

Objectives: To assess the quality of the consultation process from the perspectives of the patient/family, referring physician and consultant psychiatrist. **Methods:** Patients >65 y.o. referred to the out-patient Geriatric Psychiatry clinic of an acute care community hospital were consecutively enrolled. Patients were assessed for competency to consent, received a SPMSQ then filled (with family if needed) a questionnaire on sociodemographic variables and the OARS questionnaire for daily functions and ability to carry out activities. The psychiatrist filled the consultation and a questionnaire after the visit. The patient/family completed the consultant satisfaction questionnaire after the visit. One month after the consultation a phone (or mail in) questionnaire was completed by the referring physician. **Results:** 149 patients were enrolled. 66 were referred for depression, 31 for no-depression (anxiety and dementia) and 52 other requests were too vague to categorize. The average age of patients was 77 years. Despite an overall general satisfaction of 80%, patients were less satisfied with the depth of relationship and the length of consultation. Over 75% of referring physician were satisfied with the report, rating it as useful in more than 90% of cases. Concordance between the referring and consulting physicians on the type of consultation requested was 44%, on the reason for referral 45%, and on who should implement the recommendations, 71%. **Conclusion:** This study highlights some of the obstacles that need to be overcome in order to have an effective shared-care mental health approach for seniors.

Apolipoprotein E: A Pharmacogenomic and Therapeutic Target for the Treatment of Alzheimer's Disease

Judes Poirier, D.Sc. Directeur, Centre for studies in Aging, Department of Psychiatry, Douglas Hospital, McGill University, Montreal, Quebec.

The discovery that a particular polymorphism in the apolipoprotein B gene (called apoE4 allele) is strongly

linked to both sporadic and familial late onset Alzheimer's disease (AD) raises the possibility that a dysfunction of the lipid transport system could seriously affect lipid homeostasis in the brain. ApoE is a key transporter of cholesterol and phospholipids in peripheral organs and in the brain. We proposed that the abnormally low concentrations of apoB observed in the brain of apoE4-carrier with AD could compromise cholesterol, fatty acids and phospholipids transport in the CNS. This, in turn, would indirectly impair the so-called cholinergic system which, in contrast to other neurotransmitters in the CNS, relies heavily on lipids to synthesize acetylcholine. Acetylcholine is a key player in learning and memory in humans. Indeed, several independent investigators have now confirmed the observation of an inverse relationship between apoE4 allele copy number and residual synthesis of acetylcholine in the brain of AD subjects. More importantly, we found that the presence of the apoE4 allele differentially affects the quality and size of drug responsiveness in Alzheimer's subjects treated with cholinomimetic and noncholinomimetic agents. We will also discuss the case of ProbucoL, an experimental apoL-inducer drug that was shown to promote apoE synthesis and secretion in astrocyte cultures, in mouse and rat brain structures and in the brain of AD patients exposed to pharmacological concentrations of the drug for 4 weeks. Finally, the role of apoB as both, a potent pharmacogenomic marker and therapeutic target for Alzheimer's disease will be discussed in the context of the post-genomic era.

* Supported by the Canadian Institute of Health Research and the Alzheimer's Society of Canada.

Psychosocial Risk Factors in Poststroke Depression: A Systematic Review.

M.A. Guimet, MD, Resident in Psychiatry, CAGP Fellow

Objective: To systematically review the psychosocial risk factors for poststroke depression. **Methods:** Medline was searched using the key words poststroke depression for the period January 1 1966 to June 30, 2000; using the key words cerebrovascular disease and depression it was searched June 1, 1996 to June 30, 2000. Corollary articles were obtained from the bibliographies. Inclusion criteria were as follows: original research in French or English; prospective, case-control or cross-sectional study design; assessment of poststroke depression in the first 6 months following the stroke; an acceptable definition of depression; an acceptable definition of stroke and at least one psychosocial risk factor. Interrater reliability was tested for the selection and quality of the articles. A qualitative risk factor analysis was conducted. **Results:** The risk factors most commonly associated with poststroke depression are a past history of depression,

past personal psychiatric history, dysphasia, functional impairments, living alone, and poststroke social isolation. Risk factors not associated with poststroke depression are dementia and cognitive impairment. Controversial risk factors are age, socioeconomic status, prior social distress, dependency in regard to activities of daily living and sex. **Conclusions:** Over 30 years approximately 25 qualitative studies addressed psychosocial risk factors for poststroke depression. Further studies should aim for quantitative analysis. The results suggest that identification of past psychiatric history and prevention of social deterioration and impairment should be part of multidisciplinary efforts in the care of poststroke patients.

Cognitive Behavioral Therapy for Depressed Elders: A Comparison of Group Therapy and Self-Help Bibliotherapy

Natasha Frolic, MD, B.Sc., CAGP Fellow

Objective: To investigate whether elderly depressed outpatients would respond to cognitive behavioral therapy (CBT), and if so would there be a difference between group therapy and self-help bibliotherapy (both using the same CBT manual) compared to a wait-list control group. **Methods:** Inclusion criteria : (a) age ≥ 65 years; (b) no substance abuse, psychotic disorder, bipolar disorder or immediate suicidal risk; (c) no concurrent treatment with other formal psychotherapies; (d) no significant cognitive impairment [Mini-Mental State Examination (MMSE) ≥ 25]; (e) stable doses of psychotropic medication for the previous 3 months; (f) adequate reading skills; (g) Beck Depression Inventory (BDI) scores ≥ 17 ; and (h) a diagnosis of Major Depression (as indicated by psychiatric evaluation using DSM-IV criteria). Outcome measures to be done prior to entering the study (Time 0) and after completing the 6-week treatment period (Time 1) include the Montgomery and Asberg Depression Rating Scale (MADRS), the Beck Depression Inventory (BDI), the Lawton Instrumental Activities of Daily Living (Lawton IADL) scale and the Clinical Global Impression Scale (CGI). Both the group CBT and self-help bibliotherapy group will have the same client manual. The group therapy participants will participate in 12 hours of CBT. The participants in the self-help group will be contacted by telephone with weekly 10-minute calls to clarify points in the text and encourage participants to complete the manual within 6 weeks. The wait-list group will receive no written material and no additional therapeutic interventions. **Conclusions:** This study is on-going in an altered form. I will discuss complicating factors, learning points in the project and findings thus far.

Risk Factors for Institutionalization in Community Dwelling Alzheimer Disease

Michel Elie, MD, FRCPC, St-Mary's Hospital, McGill University, Montreal, Quebec.

The aging of the population will have a major impact on future health resources utilization. Specifically, elderly individuals with degenerative dementia of the Alzheimer's type will account for a larger proportion of institutionalization resources. The goal of this study is to do a systematic review of the literature looking at risk factors for institutionalization in elderly community living individual with Alzheimer's disease. A systematic search was done using Medline and Psychinfo from 1980 to 1999 using the words DEMENTIA, INSTITUTIONALIZATION, LONG TERM CARE, RISK FACTORS. Inclusion criteria were: original article in French or English, looking at at least one risk factor for institutionalization of community dwelling elderly patients with Alzheimer's disease. A total of 14 papers meeting all of these criteria were identified. Over 20 different risk factors were identified. The 4 main risk factors were aggressivity, wandering or incontinence of patient and caregiver depression. Methodological weaknesses were present in most articles. The decision to institutionalize a demented person is complex and multidimensional. More studies are needed to specifically identify the most important reversible risk factors.

Therapeutic Efficacy of Cholinesterase Inhibitors for Neuropsychiatric Symptoms of Dementia.

Francois Rousseau, MD, M.Sc. FRCPC, Centre hospitalier Robert-Giffard, Laval University, Quebec, Quebec.

Behavioral and psychological symptoms of dementia (B.P.S.D.) are numerous and frequent. They are associated with significant morbidity for demented patients and are related to a high burden for caregivers. The conventional behavioral and pharmacological treatments often have a significant, but partial efficacy in stabilizing these manifestations.

The focus of this workshop is to review and discuss the literature concerning the potential usefulness of cholinesterase inhibitors, a class of medications recognized as symptomatic treatment of Alzheimer's disease, as a stabilizing treatment of neuropsychiatric symptoms of dementia. Clinical cases, illustrating this potential therapeutic option, will be presented.

Objectives:

1. Increase the clinician's ability to recognize the neuropsychiatric symptoms of dementia.
2. To review the pharmacotherapeutic options for the B.P.S.D.

3. To identify patients affected by B.P.S.D. who can benefit from treatment with cholinesterase inhibitors (ChEIs).
4. To target neuropsychiatric symptoms that can be potentially improved by ChEIs.
5. To consider rational prescription of ChEIs in subgroups of patients affected by moderately to severe dementia.

How to Set Up a Rural Teleconferencing Program

Lonn Myronuk, MD, FRCPC, Central Vancouver Island Health Region, Nanaimo, BC

Building on the experience of the presenter in providing sub-specialty geriatric telepsychiatry services to the communities of the Peace River area of northeastern British Columbia, this breakout session focuses on the issues likely to be encountered when trying to establish similar services elsewhere. Challenges identified in the morning's formal presentation on teleconferencing will be amplified, with specific example of each described and discussed. Emphasis will be on the clinical aspects of this medium, rather than the technical.

Starting a Dementia Clinic from Scratch

Barry Campbell, MD, FRCPC, University of Manitoba, Winnipeg.

The workshop will describe the development, function, outcomes and characteristics of a Memory Assessment Clinic in Winnipeg, Manitoba. The clinic has been assessing patients for just over 2 years. Dr Campbell is the director of the clinic.

The goals of the presentation are to familiarize the attendees with the concept of a memory clinic and to provide a forum for discussion.

Development of an Inpatient Geriatric Psychiatry Program in a Community General Hospital

Goran Eryavec MD, FRCPC & Sophia Lilly, R.N., Division of Geriatric Psychiatry, North York General Hospital, Toronto, Ontario

North York General Hospital is a community general hospital in Toronto, Ontario. Prior to June 2001, the hospital did not have any dedicated psychiatry inpatient beds or staff to treat patients aged 65 and over who were admitted with psychiatric illness. Elderly patients were admitted to the 30-bed general adult psychiatry unit and usually occupied 6 of the 30 inpatient beds.

After the hospital amalgamated with another community general hospital in Toronto, 15 additional general adult inpatient psychiatry beds were scheduled to open in June 2001. It was expected that geriatric patients would occupy 10 of the 45 inpatient psychiatry beds. Efforts ensued to develop a 10-bed inpatient geriatric psychiatry program, with dedicated multidisciplinary geriatric psy-

chiatry staff, to better serve the needs of mentally ill elderly patients requiring inpatient psychiatric care.

Resistance to the development of the inpatient geriatric psychiatry program was encountered from some of the psychiatric nursing staff who were concerned that they would have to care for large numbers of demented or physically frail elderly patients. Such patients were previously cared for on the medical wards of the hospital. Many staff meetings were needed to clarify the admission criteria for the new program and to reassure nursing staff that they would not be caring for a new population of frail and severely demented elderly patients.

Once the inpatient geriatric psychiatry program was accepted, a multidisciplinary program planning committee was formed and made three site visits to established inpatient geriatric psychiatry programs in the province of Ontario. Several geriatric psychiatry rounds and a week long education and program planning retreat were held for the staff of the new program. Program goals, staffing, activities, admission criteria and admission process were clarified. A program brochure for patients and families was developed. An open house was held prior to the opening of the program.

The inpatient geriatric psychiatry program has operated at full capacity and has been well received by patients, families, program staff, the hospital and the community. Satisfaction surveys have been completed by patients and/or family members on discharge. The main challenge has been to maintain clear admission criteria for the program and to help the medical wards in caring for demented and physically frail mentally ill elderly patients. We believe our program can serve as a model for other community general hospitals.

Average Sunrise Time Predicts Depression Prevalance

Henry Olders, MD, FRCPC, Assistant Professor, McGill University, Department of Psychiatry; Attending Psychiatrist, SMBD-Jewish General Hospital, Montreal, Quebec.

The striking differences in depression prevalence between nine European cities in the EURODEP geriatric depression Programme, or between five U.S. centres in the Epidemiologic Catchment Area (ECA) Study, lack satisfactory explanations to date. Given the links between light and depression, published prevalence data from these two studies were analysed to look for a relationship to sunrise time.

Depressive neurosis prevalences from the EURODEP Programme and one-year depression prevalences from the ECA study were plotted against each centre's sunrise time, averaged over one year, and Pearson correlation coefficients calculated. For both studies, de-

pression prevalences are highly negatively correlated with average sunrise time.

This suggests that a city's average sunrise time, determined primarily by east-west position within its time zone, may predict depression prevalence, and that simple public health measures such as going to Daylight Saving Time year-round or shifting time-zone boundaries, could reduce depression rates.

Canadian Invitational Symposium on Gaps in Mental Health Services for Seniors in Long Term Care Settings

SHELLY HABER & DAVID CONN

The CAGP continues to provide leadership in the mental health system by initiating the Millennium Project, through the CAGP co-chairs, David Conn and Ken LeClair. The Project's purpose is *"to improve mental health of the elderly in long term care through education, advocacy and collaboration"*. To further this goal a National Invitational Symposium or "think tank" has been scheduled for April 28th and 29th 2002 in Toronto at the Toronto Colony Hotel. Direction for the Symposium is being provided in collaboration with the following organizations:

- ◆ The Canadian Academy of Geriatric Psychiatry
- ◆ Canadian Society of Consulting Pharmacists
- ◆ College of Family Physicians of Canada
- ◆ Health Canada
- ◆ Canadian Geriatrics Society
- ◆ Canadian Mental Health Association
- ◆ Canadian Alzheimer Association
- ◆ Canadian Nurses Association
- ◆ Canadian Association of Retired Persons
- ◆ Canadian Association for Community Care
- ◆ Canadian Psychological Association, and
- ◆ Canadian Association of Social Workers.

More information is available from Shelly Haber, at the address listed in the article.

To date the Symposium has over 90 registrants. Many more people have requested to participate in this event but, due to limited registration, had to be put on a waitlist. Space continues to be held on reserve for under-represented groups. Registrants for the Symposium include national and provincial governments, national and regional health care providers, national policy and research organizations, representatives from the education sector, and consumer associations.

A description of the project is available on the CAGP web site (www.cagp.ca) and is in the process of being posted on the International Psychogeriatric Association web site. The relevance of the project has also been referred to in briefs made by national organizations sent to the Romanow Commission.

What Next

After the Symposium stakeholders will be invited to participate in a meaningful way in an ongoing coalition/network whose mandate will be to implement the action plans/strategies that arise from the Symposium. Stakeholder participation/commitment will be considered a key success factor of the Symposium.

A proposal was sent to Health Canada, Population Health Fund to apply for post Symposium funding to create a national coalition whose purpose will be to implement the recommendations that arise from the two day discussions. The CAGP is awaiting a response.

The steering committee will determine which recommendations can be implemented within current resources through networking, creating linkages and the expertise/leadership of its membership.

The steering committee will also oversee the development of two educational inventories, which will:

- ◆ *enhance the capacity of front line workers and informal caregivers in care facilities to better meet the mental health needs of seniors living in long term care settings; and*
- ◆ *inform family members about resources to*

enhance their capacity for support to residents with mental health needs.

There are currently many excellent educational resources available across Canada and beyond. Some of these resources have been made readily available through distribution, web sites, etc. Other educational materials are more unfamiliar or unknown. The challenge is to provide educational materials to front line workers and to families, which are highly organized, relevant, concisely presented and widely disseminated.

Stakeholders interested in the educational initiative will participate in a process that will define specific education objectives for the inventories (one for front line caregivers and one for families) and develop classifications/categories for each inventory (e.g. target populations, timeliness, presentation structure, description of content, etc).

Project Results

The project will enhance the mental health of seniors living in long term care settings and their families by:

- ◆ The development of a formalized coalition of committed stakeholders to implement new initiatives resulting from the Symposium.
- ◆ Linking with government agencies and provider/consumer groups to have the action plans implemented.
- ◆ Creating awareness of the issues and opportunities through ongoing advocacy and collaboration.

- ◆ The development of two inventories of educational products aimed at a) enhancing front line staff and b) families, capacity to be effective in meeting the mental health needs of seniors. The inventories of educational products will be widely disseminated to long term care organizations and educational institutions.

Contact

If you require additional information regarding this event please contact:

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Evidence Based Medicine
Safety of Depot Antipsychotic Medication

ROB VAN REEKUM & NADINE COSSETTE

Clinical Case:

86 year old woman with vascular dementia and agitation. Good response to oral Risperidone, but frequently non-compliant.

Clinical Question:

Are depot neuroleptics safe in the geriatric population?

Literature Search:

neuroleptic agent, depot, long acting, delayed action, antipsychotic agents

EMBASE: 1980- 2001, MEDLINE 1993 - 2000

Conclusions	Study type
Depot neuroleptic may not increase risk of EPS or TD in geriatric age range.	Open Label ¹ Cross-sectional ⁶
	Case Series ⁷
Depot neuroleptics may have significant risk of EPS and TD in geriatric age range.	Nonrandom Controlled Trial ²
	Case Control ³
	Descriptive Survey ⁴
Side effects of Depot Neuroleptics (EPS) may lead to lethal complications.	Case Series ⁵

Recommendations:

There is insufficient evidence regarding safety of depot neuroleptics in geriatric patients; however, there is anecdotal evidence of lethal side effects. Other routes for administration of antipsychotic medications to uncooperative but incapable elderly patients need to be developed.

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Evidence

No significant change in NRS or AIMS over 16 weeks. Two patients discontinued depot medication due to EPS.

Non-significant trend for lower AIMS score for those receiving depot medication.

Significant decrease in rigidity, EPS Sum Scores, and vegetative symptoms. No significant change in: akathisia, tremor, TD. However, 43% drop out

depot fluphenazine vs. oral haloperidol; Depot: 15 side effects in 8 patients (4 severe parkinsonism, 5 fatigue, 4 depressed mood, 2 dry mouth).

Oral: 10 side effects in 8 patients: None severe (4 parkinsonism, 3 fatigue, 1 blurred vision, 1 orthostatic hypotension).

13.8 times more likely to be prescribed an antiparkinsonian if on depot neuroleptic versus no neuroleptic at all. 5.4 times more likely to be prescribed an antiparkinsonian if on any neuroleptic.

Mod-severe: tremor 10/98, rigidity 5/98, TD 5/98.

Mild or worse: tremor 39/98, rigidity 30/98, TD 32/98.

Each worse with higher dose.

N=4. Depot neuroleptics led to total loss of mobility due to rigidity, which led to death from bronchopneumonia (3) and urosepsis (1). Likely underlying Lewy Body Disease.

Evidence Based Medicine **Modafinil: Evidence for use in anergia?**

ROB VAN REEKUM

The Bulletin is reprinting this review in its entirety this issue because printing errors led to the omission of part of the article last issue. This series of evidence-based medicine reviews is based on work performed by educators and learners at the Baycrest Centre for Geriatric Care in Toronto. Requests or suggestions of topics for review or evaluation are welcome, and can be directed to Dr. van Reekum via E-mail care of the Baycrest Department of Psychiatry, arizzuto@baycrest.org.

Clinical Case:

A 67-year-old man presented with complaints of excessive fatigue following a traumatic brain injury.

Clinical Question:

Is modafinil efficacious for the treatment of anergia (lack of energy, fatigue) in persons with disorders of the brain (not including narcolepsy)?

Literature Search:

PsyINFO: modafinil (title word), 1984-2000
EMBASE: modafinil (key word), 1980-2001
MEDLINE: modafinil (title word), 1997-2000

Conclusions:

Modafinil lacks sufficient evidence for routine use as treatment for anergia at the present time, but shows

Conclusions	Study type
Modafinil may be useful as an augmenting agent in depression (especially for the fatigue of depression).	Case series ¹
Modafinil may be helpful for the sleepiness of idiopathic hypersomnia.	Case series ²
Modafinil produces subjective effects similar to caffeine and unlike amphetamines.	RCT-crossover ³
Modafinil may increase cerebral alertness and cognitive functioning in recently abstinent cases of alcoholic dementia.	RCT ⁴
Modafinil may maintain attentional and cognitive functioning in sleep deprivation.	RCT-crossover ⁵
	RCT ⁶

promise for the future. Randomised clinical trials of modafinil for anergia are supported by the currently available evidence.

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Evidence

7/7 subjects with treatment-resistant DSM-IV depression improved quickly on the HAM-D (especially regarding fatigue) with modafinil (100-200 mg/day) augmentation.

8/17 subjects with idiopathic hypersomnia were felt to improve clinically.

16 young, healthy volunteers reported that a single dose of modafinil felt similar to a dose of caffeine, and dissimilar to a dose of placebo or dextroamphetamine.

Alcoholic dementia (ICD 9:291.2) cases improved cognitively with modafinil 200 mg BID vs. placebo. Their EEG's showed less delta / theta activity.

Attentional speed was maintained with modafinil 300 mg/d over 60 hours of sleep deprivation while it declined with placebo.

Modafinil improved cognitive performance during 64 hours of sleep deprivation vs. placebo, but also led to "over-confidence" in self-monitoring.
