



CAGP

Bulletin

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THOSE WACKY, PUNCH-DRUNK KNUCKLEHEADS

Lonn Myronuk

I never realized as a child that when my father quipped, “He doesn’t know if he’s punched or bored!” that my father was passing on a pearl about the potential phenomenology of traumatic brain injury (TBI): emotional blunting and apathy. Indeed, our vernacular includes a host of notions, like those in the title of this editorial, that allude to the consequences of receiving blows to the head. “Wacky” suggests fatuousness, emotional lability, disinhibition. We expect “knuckleheads” to have impaired cognitive abilities, and perhaps poor judgement.

In this issue of the *Bulletin* we look at brain injury, from the perspective of prevention in Dr Kiraly’s second instalment in the *Healthy Brain* series. We also have an item in our *Evidence-Based Medicine* series that critically appraises the literature on the *Test of Malingered Memory*, an instrument that is most likely to be encountered in a medical-legal context.

As psychiatrists, it is timely for us to be considering these issues. Head injuries are unarguably a significant cause of behavioural and psychological symptoms, an estimated 2% of the American population currently living with disabilities related to TBI (Thurman, 1999). As geriatric psychiatrists, our need to address TBI is urgent: Deaths from fall-related TBI among those age 75 and over increased over 50% during the decade 1988-1998 (Reuters, 2002). Despite an overall reduction in the rate of TBI during that interval, the rate of TBI among seniors rose, and falls are the number one cause of TBI among the elderly (CDC, 1999). Six percent of fall-related TBI hospitalizations among the elderly result in death. Of the survivors, only 2/5 will be able to be discharged home or to non-

skilled caregivers. For the old-old (over age 85) only 30% will return home (CDC, 2003).

With our ageing population and as individuals continue to live longer, we will see growing numbers of elderly with TBI. One in three seniors living at home and half of those residing in institutions fall each year. Half of these will fall repeatedly (Kannus et al, 1999). Despite this prevalence, sequelae of TBI often fall “outside the mandate” of community mental health programs, and inpatient psychiatry services.

This growing segment of the clinical population is as deserving of our care and attention as any other. We should not permit the fear of involvement in injury litigation to lead us to discriminate against this patient group. I encourage you to accept referrals for the psychiatric consequences of TBI, and I urge you to advocate at your local level for these patients to be included among those served by publicly funded mental health programs.

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PRESIDENT'S REPORT

David Conn

I hope that you have all had an enjoyable summer. As we look to the fall, please mark your calendars and plan to join us for the Annual Scientific Meeting of the Academy in Halifax. The meeting will be held immediately following the CPA meeting on Monday, November 3, 2003. The organization of the meeting is in the most capable hands of Lilian Thorpe (Chair, Scientific Meeting Committee) and Terry Chisholm, local organizer. The program looks excellent and will include presentations by Drs. K. Rockwood, N. Herrmann, K. Rabheru, J. Rylett, T Chisholm, L. Hazelton, K-L Cassidy and F. Rousseau as well as presentations by our resident award winners. Details can be found on our website at www.cagp.ca.

I would like to draw to your attention that this will be the last meeting organized by Lilian Thorpe, who will be stepping down from her positions at the end of the year. On behalf of the Board of the Academy and the membership, I want to extend our heartfelt thanks to Lilian for her enormous contributions to the Academy over the past 12 years. In addition to her outstanding work for the Annual Scientific Meetings, she edited our Bulletin for many years, played an essential role in the organization of the 1999 IPA Congress in Vancouver and she has also served as our Vice-president for the past three years. We hope that Lilian will continue to be available to us as a consultant in the years to come.

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The Academy and the Canadian Coalition for Seniors' Mental Health have been active on many fronts including a joint written and oral submission to the Senate Committee on Social Affairs, Science and Technology (Chair, Michael Kirby) in early June. Details can be found in this edition of the Bulletin.

With regard to the ongoing issue of recognition of the sub-specialties in psychiatry, I must report that the process of approval by the Royal College appears to have reached yet another hurdle. Unfortunately, there remain considerable differences within psychiatry with regard to how to proceed. At this point, one of the key controversies revolves around the issue of whether an extra year of training beyond the residency should be required in order to achieve sub-specialty status. We will, of course, keep the membership informed of any further developments.

I am delighted to inform you that Nathan Herrmann has agreed to edit the special geriatric edition of the Canadian Journal of Psychiatry, which will be published next year.

I would like to encourage you all to attend the second Canadian Colloquium on Dementia, which will be held in Montreal October 16-18, 2003. The CAGP is a co-sponsor of the meeting along with the Canadian Neurological Society, the Canadian Geriatric Society and C5R. For information on the Colloquium, please see the website at www.2ndccdconference.com.

Finally, I would like to congratulate Serge Gauthier on his election to the Board of the International Psychogeriatric Association. He will join fellow Canadians Joel Sadavoy (President Elect) and Ken Shulman.

ORAL PRESENTATION

To the Standing Senate Committee on Social Affairs, Science and Technology

The following is the oral presentation made to the Senate Committee
in June 2003 by David Conn

Good afternoon, my name is David Conn, I'm a geriatric psychiatrist working at Baycrest Centre in Toronto. I'm President of the Canadian Academy of Geriatric Psychiatry (CAGP) and co-chair of the Canadian Coalition for Seniors Mental Health (CCSMH), which represents more than 65 organizations from across the country. We would like to thank the Committee for inviting us to present on the unique issues facing seniors' mental health. With the rapid growth of the aging population there will be an unprecedented increase in the number of seniors with mental illness, with an equally striking demand on the system's capacity to address their needs.

I would first like to underline some key issues for this population:

- 1 Seniors suffer from a wide array of mental illnesses including Mood, Anxiety, and Psychotic Disorders and in addition the emotional, behavioural and cognitive complications of a variety of brain diseases such as Alzheimer's Disease, Stroke and Parkinson's disease.
- 2 Mental disorders among seniors are frequently misdiagnosed or missed altogether.

- 3 There are very high rates of mental disorders among certain groups eg the residents of LTC facilities or seniors suffering from chronic physical illnesses. Behavioural symptoms such as physical aggression or agitation frequently have serious consequences including injury, caregiver distress and premature institutionalization.
- 4 Caring for seniors is often a complex affair. Older seniors are commonly frail, have coexisting health conditions and are frequently taking multiple medications.
- 5 We do have effective treatments but those in need often don't receive them. On the other hand inappropriate or suboptimal use of psychoactive medications is an issue of major concern. This can represent either overuse or in some cases underutilization of medications.
- 6 There is a distinct lack of public awareness about these issues.
- 7 Training of frontline staff is often woefully inadequate, although there are some recently developed model programs in a few areas of the country, which are demonstrating some success.
- 8 Family caregivers experience extraordinary levels of stress over long periods of time.

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- 9 There is a desperate need for available mental health services for seniors, which must be comprehensive, coordinated and integrated with the rest of the health care system.
- 10 There is a particular need for effective Community outreach services so that seniors who require assessment and treatment in their homes can be adequately cared for.
- 11 There is a serious lack of research and information regarding this population.
- 12 Primary prevention is a vitally important goal but effective strategies remain somewhat elusive.

We would like to begin by suggesting that the Federal Government in collaboration with the Provinces and other key stakeholders jointly develop a National Action Plan for Mental Illness and Mental Health. Within that Plan there needs to be a specific focus on seniors and their unique needs and issues.

I would like to focus our attention to the following areas:

- Public Awareness
- Education
- Systems of care
- Human Resources
- Research
- Caregivers

In each area we would like to put forward 1 or 2 suggestions for your consideration.

A - PUBLIC AWARENESS

There is a growing need for public education about mental problems associated with aging. Mental Illness is not a natural part of aging, nor does it have to be seen as shameful or an embarrassment. A lack of knowledge regarding early “signs” of mental illness and effective treat-

ments prevents seniors and their families from accessing much needed services on a timely basis. Indeed early identification contributes to better treatment outcomes. For example, timely diagnosis can allow for the use of newly discovered therapies, which can slow the progress of Alzheimer’s disease. In addition early identification of depression may reduce morbidity and also decrease the incidence of suicide in seniors. It is very important to note that the incidence of suicide among men 80 years of age or older is the highest of all age groups in Canada!

Recommendations

- We recommend that the Federal Government provide funding for the development of a public education campaign (in collaboration with multiple stakeholders e.g. CCSMH, CAGP, others) to increase awareness of mental health concerns in seniors.

B - EDUCATION

The number of health care professionals with training in geriatrics is completely inadequate. We need to ensure that geriatric education is part of the core curriculum for all health care disciplines and receives appropriate emphasis. Geriatric specialists are currently in short supply and demographic trends will further exacerbate the situation.

In long-term care facilities 80% of residents suffer from some form of mental disorder. Indeed nursing homes have been termed the modern mental institutions for the elderly. Yet staff in these facilities receive very limited training with respect to mental health problems.

Recommendations

- Educational strategies are especially needed which target frontline workers

in both the community and in institutions. This could be achieved through collaboration of the Federal government, Canadian Council on Health Service Accreditation and other key stakeholders. The minimum standards defined within the accreditation guidelines should include a specific number of hours of education for all staff in long term care facilities and home care agencies.

C - SYSTEMS OF CARE

There are vast discrepancies in the availability of mental health services between different regions of the country, with very limited availability in rural areas and smaller cities. In most regions, services that do exist are poorly coordinated, are not comprehensive and do not have the capability of serving multicultural communities. Community outreach is an essential component of geriatric care, as many seniors are reluctant or unable to leave their homes. Telehealth allows specialized assessment and education to reach remote areas.

Recommendations

- We would like to see sponsorship of a national “Best Practices” conference focusing on seniors’ mental health – so that we can all learn from the best of what is available across the country.
- A national committee should be created to develop evidence-based guidelines (or standards) on Assessment, Treatment and Service Delivery Models. Funding should be made available to support the development, dissemination, implementation and evaluation of these guidelines.
- We also recommend provision of financial support for Geriatric Telehealth initiatives, which can provide remark-

ably effective mental health consultation and education to rural and remote areas of the country.

D - HUMAN RESOURCES

The members of our Coalition and Academy believe that one of the most significant barriers to seniors’ mental health is the shortage of human resources. It is difficult to recruit and retain qualified staff. Long Term Care settings are particularly vulnerable to high rates of staff turnover. More information is needed regarding the specific human resources that are required to effectively deliver care; and how we can create work environments that will attract qualified professionals and front line workers.

Recommendations

- We recommend support for a national health human resources strategy that includes issues specific to seniors’ mental health. The strategy should address supply, distribution, recruitment and retention strategies, remuneration and credentialing.

E - RESEARCH

There is currently relatively little research being conducted in Canada on seniors’ mental health. Although there is some very limited funding for Alzheimer’s disease, much more is needed for the full array of mental health issues. There is no organized research agenda that focuses on seniors’ mental health. Furthermore, there is very little data collected nationally to allow us to understand the incidence and prevalence of various disorders as well as the outcome of treatments and programs for seniors’ mental health.

Recommendations

- We recommend that a workshop be supported by the Federal Government and coordinated by key stakeholders (CCSMH, CAGP, others) to establish seniors' mental health research priorities. The results of the workshop should lay the foundation for targeted funding for geriatric mental health research. This should be supported through Canadian Institutes for Health Research (CIHR) and Canadian Health Services Research Foundation (CHSRF) with the goal of enhanced funding for basic, clinical and health systems research.
- The Canadian Institute for Health Information in collaboration with the provinces and territories should be encouraged to create a working group to collect data specifically related to seniors' mental health, in both community based and long term care settings.

F - CAREGIVERS

Family caregiving is a tremendous task; it places immense demands on time, resources and emotions. Due to the enormity of the task, caregivers of older people have very high rates of depression. The economic value of family caregiving is enormous. Family caregivers

provide the majority of long term care in Canada and save billions of dollars for the public system. However, supports to family caregivers are limited, usually insufficient and mostly geared to the needs of the ill family member, not to the needs of the caregiver.

Recommendations

- We recommend the provision of family caregivers with the necessary supports to successfully provide care, including sources of relevant and meaningful information and the availability of appropriate levels of respite care and homecare.
- We also recommend the provision of tax credits or tax breaks to reflect actual costs for out of pocket expenses incurred by caregivers.
- It is also important to continue to review and make change to employment insurance, pension plans and labour codes to accommodate caregivers' needs to take time off work when necessary, without risking job loss.

I would like to end with a quote from C. Everett Koop (a U.S. Surgeon General):

“The capacity of an individual with mental or behavioural problems to respond to mental health interventions knows no end-point in the life cycle.”

THE HEALTHY BRAIN PROGRAM: PRECEPTS OF BRAIN HEALTH - SAFETY

Traumatic Brain Injury (TBI) and Mild Traumatic Brain Injury (MTBI) are Precursors to Delayed Onset Brain Disorders Including Early Onset Dementia.

Stephen J. Kiraly, MD, FRCPC

ABSTRACT:

Problem addressed: The Healthy Brain Program (HBP) is comprised of eight precepts: safety, nutrition, physical exercise, mental exercise, stress management, sleep, hormone balance and treatment of diseases which are independent risk factors for brain disorders. In this article, the second of the series, the importance of BRAIN SAFETY is addressed. Most people are unaware of the high incidence of traumatic brain injury (TBI) and its horrendous consequences.

Objectives: 1) To increase awareness of the magnitude of the problem and its long term, delayed consequences. 2) To instil an appreciation of the importance of preventing all brain injuries. 3) To increase physician confidence in educating patients, making timely diagnoses and implementing important treatments for TBI.

Main components and methods: Studies are reviewed which show correlations between TBI and a variety of brain disorders and psychiatric syndromes. The epidemiology of TBI is summarized. Evidence from animal experiments, human post-mortem and population studies is introduced to demon-

strate the links between TBI and subsequent onset of premature neurodegenerative diseases, including Alzheimer's and Parkinson's disease.

Conclusion: There are protocols for the diagnosis and grading of TBI which enable the physician to be more definitive in counselling patients and managing TBI and concussion. The aim is to protect the brain. Prevention is the only cure.

“With respect to the phenomenology of MTBI, there are believers and non-believers. You don't convert until it happens to you or someone close to you.”

- William D. Singer,

Harvard Professor of Neurology & Paediatrics, 2002

Trauma to the head is dangerous. Dementia pugilistica is a well documented organic brain syndrome showing heavy amyloid deposits (1). Many people are unaware that even mild head trauma, the kind sustained in everyday sports and minor accidents, can take a toll by reducing brain reserve and paving the way for a variety of brain disorders with delayed in onset. TBI has been aptly called the silent epidemic (2).

This review focuses on studies which have emerged as evidence that TBI is an epigenetic risk factor for brain disorders

For more information refer to:
<http://www.healthybrain.org>

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including personality changes (6-9), depression (10-14), mania (15,16), anxiety disorders (17), obsessive compulsive disorder (18), schizophrenia (19,20), posttraumatic stress disorder (PTSD), (21,22) and Parkinson's disease (PD) (23,24). The evidence is convincing for a strong association between TBI and mood and anxiety disorders. Substance abuse and schizophrenia are not strongly associated with TBI, but evidence for correct temporal sequence is present. Mild TBI is more likely to be associated with PTSD (inverse gradient) (25). New research is of great interest to the geriatric specialist because it suggests that brain injury leads to an increased risk of developing dementia, including AD (26). Salient studies on TBI and neurodegeneration serve as evidence-based arguments for "SAFETY" - the most intuitive and obviously important component of the Healthy Brain Program which was introduced in a previous issue of the Bulletin (27).

The Extent of the Problem:

Epidemiology

Head injuries are far too common but, for complex reasons, medical education does not mirror the high prevalence of this disorder. TBI is one of the most common neurological disorders with a incidence of 180/100,000. This is equal to the annual incidence of PD, multiple sclerosis, Guillain-Barre syndrome, motor neuron disease and myasthenia gravis combined. Fifteen percent will be persistently symptomatic (28). Disorders arising from TBI are more numerous than any other neurological disorder with the exception of the common headache (29). Motor vehicle accidents, falls, assaults and various sports-related activities result in TBI that affect about 7 million individuals each year in North America (30). Before 1999 in the U.S., 2.5 to 6.5 million people lived with the long term consequences of TBI (31). More recent reports indicate that this esti-

mate at 5.3 million. A little more than 2% of the U.S. population currently live with disabilities resulting from TBI (32). TBI remains the leading cause of mortality and serious morbidity amongst young adults and children.

A bump on the head may have serious consequences depending on previous vulnerabilities (host factors), what kind of injury was sustained, how it injured the brain and how the brain reacted to it. Studies of age-specific factors show that the young and the old are high risk groups (33). After one brain injury, the risk for a second injury is three times greater; after the second injury, the risk for a third injury is eight times greater (34). Shaken Baby Syndrome alone affects 1/4000 and carries a death rate of one in three. Only one third seem to remain without sequelae. Rotational forces were the most deleterious (35). Athletes in full-contact sports such as boxing, football, hockey, and soccer are exposed to single and repeated concussions, which may result in subdural haematomas, loss of cognitive function or death (36). TBI incidence clusters around specific high risk behaviours such as snowmobiling (37), heading the ball in soccer (38), or in-line skating (39). Males, especially young men, are more prone to TBI with immediate and/or delayed sequelae. Males are more likely than females to avoid treatment or minimize the injury. Young males with TBI tend toward problems in the attention deficit-hyperactivity spectrum; young females towards labile mood and depression. Older age groups of both genders are more vulnerable to cognitive deficits and frank dementia. People with residual deficits tend to lack insight and underestimate and under-report their disabilities (40). Direct impact need not take place; sudden rotation is as likely to produce injury. Recent findings demonstrate not only that a gradient of increasing concussion severity is represented by posttrau-

matic amnesia (PTA) and loss of consciousness (LOC), but also that measurable neurocognitive abnormalities are evident immediately after injury without PTA or LOC (41). The cost of traumatic brain injury in the U.S. is estimated to be \$48.3 billion annually (Second to AD at \$115 billion). Hospitalization accounts for \$31.7 billion, and fatal brain injuries cost the nation \$16.6 billion each year (42). Unfortunately, Canadian statistics are not lagging behind. The Brain Association of British Columbia serves as an excellent clearing house for related information (43).

Brain Reserve and Compensatory Mechanisms:

The idea that organs have reserve capacity is not new. The concept of brain reserve or neurocognitive reserve, however, is a relatively new one. It is a result of studies on healthy brains, such as the Nun Study (44) and the Centenarian Study (45), where it was noted that the extent of brain damage did not always correlate with cognitive performance (45,46). It was clear that the brain (of at least some people) could sustain a fair amount of damage before decompensating into symptomatic dysfunction and overt illness behaviour. In some studies, pathologically confirmed preclinical AD was not associated with cognitive impairment or decline, even on measures shown to be sensitive to very mild AD. (47). The lack of effective predictors of the rate of dementia progression extends to the very earliest stages of the disease, including what is often called mild cognitive impairment (MCI). Some have concluded that a new approach to the identification of correlates of rates of progression is needed (48). We do not know enough about what happens in the brain following minor damage. As in other organs, cellular repair after injury also takes place in the brain but the brain has difficulty getting rid of by-products and debris resulting from injury-related

molecular interactions. Cellular signalling after neuronal injury and the resultant cytokine cascade, microglial response and cytopathological alterations have the end result of amyloidogenesis. While beta-amyloid precursor protein (beta-APP) is neuroprotective, its fibrillogenic form, amyloid beta-peptide (A-beta) derivative of beta-APP is damaging to neuronal and glial cells and plays a major role in neurodegenerative changes following a variety of injuries including trauma and stroke (49). Apolipoprotein E (ApoE) and its isoforms also mediate neuronal protection, repair and remodelling. Over-expression of the ApoE4 allele is not only a major risk factor for AD but it is also associated with poor outcome after TBI (50). ApoE interacts with A-beta and tau proteins which in conjunction with environmental factors, contribute to the etiologic heterogeneity of AD (51). Damaged axons can serve as a large reservoir of A-beta, which may contribute to A-beta plaque formation after TBI in humans (52). As with other systems, silent damages will add up to produce organ failure.

The Evidence: Animal Experimental Studies

The evidence for intracranial effects of TBI and MTBI in humans is largely circumstantial. Experimental animal studies are repeatable and yield more easily observable evidence. Sub-threshold head trauma which does not produce brain tissue injury after a single hit was followed by abnormal accumulation of neurofibrillary material and increased tau protein immunoreactivity in rats (53). One month after percussion, degenerative changes and accumulation of cytoskeletal proteins were found in hippocampal and cortical areas. The percussed rats showed behavioural changes such as less efficient habituation to a new environment (53). In ApoE-deficient mice, mild concussive TBI was associated with widespread neuronal degenera-

tion throughout hippocampal subfields and parts of the dentate gyrus. This was accompanied by widespread glial fibrillary protein and immunoreactivity throughout the hippocampus, which was more intense in ApoE-deficient mice (54). Others have shown that ApoE3 allele is neuroprotective whereas ApoE4 increases fatalities in transgenic mice with closed head injury (55). When transgenic mice with over-expression of human A-beta were subjected to controlled concussions, there was marked atrophy of hippocampal and cingulate fields and a reduction in the deposition of AD-like A-beta. Immunohistochemical studies indicated increased activity and vulnerability to A-beta toxicity (56). When pigs were subjected to rapid acceleration-deceleration TBI without impact, diffuse axonal pathology and A-beta and tau protein accumulation in damaged fields, were the results. Some pigs also exhibited plaque formation typical of AD (57). The above controlled studies supply incontrovertible evidence that even mild subthreshold head trauma is an epigenetic risk factor for neurodegenerative changes in mammalian AD models.

Human Post-Mortem Studies:

In humans, increased expression of beta-APP appears to be part of the acute phase response to neuronal injury. Extensive over-expression of beta-APP leads to deposition of beta-amyloid protein and the initiation of an AD-like disease process within days. These findings have implications for the pathogenesis of AD (58). The first autopsy study to use brain material to study the connection between TBI and AD, confirms findings gained from clinical studies (26). The risk increases with the severity of TBI (59). It is well established that deposition of A-beta plays an important role in AD. In fatal TBI, A-beta deposition is associated with ApoE4 allele (60,61). TBI induces tau pathology with the formation of neurofibrillary tangles, another major histological marker for AD (62,63).

Population Studies:

Epidemiological data support that TBI is a risk factor for subsequent development of AD. In the MIRAGE study, head injury as a risk factor for AD was more strongly associated with subjects completely lacking ApoE4 expression (64). Saliiently, recent longitudinal studies also support significantly increased risk of all dementias and AD in populations with previous TBI (59,65). The hazard ratio increased as did the severity of TBI (59). Gottlieb reported that any medical history of head injury more than doubled the risk of AD (67). Several interpretations have been proposed to explain pathophysiology (62,66). For a review, refer to Lye and Shores (68).

Management of MTBI and Concussion:

Prevention of the second impact syndrome is most important because of rapidly increasing risk - even death; therefore, detailed protocols for diagnostic grading and treatment have been developed for TBI/concussion (28,69). Cholinesterase inhibitors used in the treatment of dementia have been found useful in treating cognitive impairment after TBI (70,71). For residual deficits new rehabilitative techniques have been explored - neurobics was born. Brain stimulation, especially novel and unaccustomed physical and mental activity produces brain derived nerve growth factors (BDNF) and related neurosteroids which promote cell division, migration and axonal growth and branching into damaged fields. Neurobics has demonstrated efficacy and has gained popularity not only as a cognitive enhancing curiosity but also as a technique for brain rehabilitation after injury (72). Informative web sites of TBI associations are on the Internet (73). We only see the tip of the iceberg but research is growing rapidly in this area. The silent epidemic of TBI will continue to be a major contributing factor to a variety of brain disorders manifesting later in the life cycle - prevention is the only cure.

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EVIDENCE BASED MEDICINE GROUP

Department of Psychiatry - Baycrest Centre for Geriatric Care

CONTRIBUTOR: DR. EILEEN SLOAN

DATE: MAY 12, 2003

CLINICAL CASE

An 83-year-old woman with a long history of musculoskeletal pain and depression is taking morphine and Percocet. The patient is demanding increased doses of medication for pain control. The family physician wishes to switch to lower potency opioids and is concerned about dependence and side effects.

Clinical Question: Are elderly patients who are treated with opioid medications for non-cancer pain at risk of dependence and what are the potential side effects?

Keywords: Opioid related disorders; narcotic related disorders; opioids and narcotics / adverse effects; aged 65 and over.

Findings: One cohort study found that neuropsychological performance i.e. vigilance / attention, psychomotor speed and working memory are impaired in chronic, non malignant pain patients on long-term opioids compared to controls but unclear if assessors were blinded to diagnosis and medication.(1) The evidence regarding dependence in elderly patients on long-term opioids is poor. (2,3) The findings from these cohort studies are conflicting and patient selection, inclusion / exclusion criteria was inappropriate or unclear. A community survey indicates a strong association between depression and opioid use but causality cannot be determined.(4) A prospective cohort study indicates that

where elderly patients suffer from substance dependence, counselling, education and support can significantly impact on use.(5)

Clinical Recommendation: Long-term opioid use likely impairs neuropsychological performance in the elderly and may cause depression. There is insufficient evidence to support concerns about dependence and abuse.

Research Priority: More research needed to look at epidemiology of opioid addiction / abuse in the elderly and at the impact of long-term use on areas such as mood and neuropsychological performance.

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EVIDENCE BASED MEDICINE GROUP

Department of Psychiatry - Baycrest Centre for Geriatric Care

CONTRIBUTOR: DR. R. VAN REEKUM

DATE: MAY 17, 2003

CLINICAL CASE

A 63-year-old female feels that her post-concussion memory problems cause her to be unable to work. She has been refused compensation based on results of testing on the TOMM.

Clinical Question: What are the validity, and psychometric properties of the Test of Memory Malingering (TOMM) in detecting malingering?

Keywords: Citation search of Dr. T. Tombaugh (who is the author of the TOMM).

Findings:

- 1 There is as yet no accepted "gold standard" for the diagnosis of malingering.
- 2 Healthy controls do very well on the TOMM.
- 3 Brain injury may not affect performance on the TOMM.
- 4 The TOMM does not correlate with other measures of memory.
- 5 The TOMM has good psychometric properties in the detection of simulated malingering.
- 6 Mean scores on the TOMM are lower if TBI is associated with possible secondary gain.
- 7 The TOMM may falsely identify neurologically impaired persons as being malingerers using the recommended cut-off scores.
- 8 There are no blinded studies comparing malingerers (defined by an accepted gold standard) vs. non-malingerers.

Clinical Recommendation: The TOMM has not been validated for the detection

of malingering and hence a diagnosis of malingering, based on the TOMM, should not be considered.

Research Priority:

- 1 A gold standard for the diagnosis of malingering (of cognitive impairment) is required.
- 2 Subsequent double-blind studies of the TOMM which include malingerers and non-malingerers will then be required.

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CANADIAN COALITION FOR SENIORS MENTAL HEALTH

Shelly Haber, David Conn, Ken LeClair

The Canadian Coalition for Seniors Mental Health (CCSMH) is the product of many hours of hard work of various CAGP members. The Millennium Project Committee whose focus was to improve mental health in long term care settings through education, advocacy and collaboration, created the 2002 National Symposium on Gaps in Mental Health Services for Seniors in Long Term Care Settings. At the Symposium the participants recommended the development of a coalition which would help to address the issues. As a result the CCSMH was created with the mandate "To promote seniors' mental health by connecting people, ideas and resources".

Much work has been done since the Symposium. Shelly Haber has been our Project Director and Drs. David Conn and Ken LeClair continue to provide leadership as co-chairs. A Steering Committee exists with 15 national organizations representing consumers, providers and policy makers. Currently we have 67 organizations that are members and over 250 interested individuals.

We believe that focusing on our goals and striving for effective outcomes has been central to our success. In the area of education we have two committees: Front Line Workers and Caregivers which have provided incredible support to the development of educational catalogues. These catalogues which list excellent educational products (books, videos, websites, programs, etc) will be used in long term care settings and associations to help enhance the care given to seniors with mental health and behavioural issues. These catalogues will be available in hard copy by the end of 2003 and will also be available in electronic format.

A web site will be established by the fall of 2003. We are creating a user friendly tool that provides information to both professionals and

consumers. Throughout the fall information will be posted to the site that will help "connect people, ideas and resources". If you have specific information that you believe is relevant to seniors' mental health and should be shared please let us know.

Brochures are under development for the general public that describe the CCSMH and provide fact sheets: one on seniors' mental health in general and a second one on specific issues related to long term care.

The CCSMH is in the early phases of developing a proposal for a research workshop. The proposal will be sent to Canadian Institutes for Health Research requesting funding for a workshop on "Setting Seniors' Mental Health Research Priorities". It is hoped that the recommendations arising from the workshop will be submitted to CIHR for inclusion in its strategic priorities.

We continue to advocate for seniors mental health through various presentations. The CCSMH and the CAGP were invited to present to the Standing Senate Committee on Social Affairs, Science and Technology on the issues and opportunities related to seniors' mental health. The presentation was very well received and is published in this edition of the Bulletin. Other presentations regarding the Coalition include the National Healthcare Leadership Conference, the Canadian Mental Health Association, the International Psychogeriatric Association, and the Ontario Gerontology Association.

We will continue to develop new opportunities to further the mission of the CCSMH. If any members would like more information about the CCSMH, please feel free to contact us.

We would like to thank the following organizations for their ongoing support:

*Health Canada, Population Health Fund
Eli Lilly Canada
Pfizer
GlaxoSmithKline
Lundbeck Canada*

CAGP members are encouraged to participate on one or more of the working groups. For additional information about the Canadian Coalition for Seniors Mental Health please contact: Shelly Haber: 416.781.2886 or Email: s.haber@sympatico.ca

MEMBERSHIP REPORT (2002-2003)

Francois Rousseau

The CAGP is a growing organization which is reflected by the ever increasing number of members. The membership criteria were clarified in the preceding years, but we will have to consider opening the door to non-physician members, because many health professionals are actively involved in the field of geriatric psychiatry. The possibility of becoming affiliate members could be very stimulating and enriching for these non-physician colleagues. In addition, many psychiatrists and other physicians involved mainly in geriatric psychiatry, and residents and fellows in psychiatry interested in this subspecialty are not members of our academy.

We will try to enhance our recruitment campaign through collaboration with the provincial psychiatric associations and the Canadian Faculties of medicine.

We welcome for membership the following colleagues for 2002-2003:

Full members: Arthur Amyot, Catherine Brassard, Keri-Leigh Cassidy, Harpreet Chauhan, William Chimich, Terry Chisholm, Michel Elie

Associate members: Biju Mathew, Peter Zelina

Affiliate members: Chantale Blanchet, Suzanne Duchon

Member-in-training: Ying Ying Grace Wu

Life members: Harry Grauer, G. Murray Irvine

REPORT OF THE EDUCATION COMMITTEE CAGP

Cathy Shea

This year, the CAGP Lilly Fellowship is awarded to Dr Suparna Madan of the University of Calgary. She has been a CAGP Resident Award winner for the past 2 years and has impressed all with her intriguing presentations on spirituality and music therapy at the annual scientific meeting in 2001 and 2002. The topic of her current fellowship research project is Caregiver Education. Dr Madan is proposing to develop a dementia newsletter for a subset of caregivers of dementia patients in the geriatric program at the University of Calgary and subsequently assessing its impact. She will be formally presented with the award at the 2003, Annual Scientific Meeting of the CAGP in Halifax but is already hard at work. Stay tuned for a report on this work at the 2004 meeting.

Five dynamic psychiatry residents who are interested in careers in Geriatric Psychiatry have won the CAGP Resident

Awards for 2003. They will all present at the Annual Scientific Meeting of the CAGP in Halifax on Monday November 3, 2003. Drs. Kris Luscombe and Neil Young from Memorial University of Newfoundland will present on two aspects of a joint research project involving the Quality of Dementia and Mental Health Information on the Internet. Dr. Laura McCabe from the University of Toronto will discuss Delirium in the Elderly. Dr. Michael Passmore, recently from Dalhousie University and now at the University of British Columbia will present on Bupropion use during ECT and Dr Julien Pelletier from Laval University will provide us with a Review of the Co-morbidity between Physical and Psychiatric Pathologies in the Elderly.

Be sure to attend the annual meeting in Halifax and congratulate our future colleagues.

THE SECOND CANADIAN COLLOQUIUM ON DEMENTIA

The 2nd Canadian Colloquium on Dementia Conference will be held on October 16-18, 2003 at the Marriott Château Champlain in Montreal, Quebec. Neurologists, geriatric psychiatrists, geriatricians, neuropsychologists, family physicians, researchers, fellows, residents, students, and other allied health professionals with an interest in Alzheimer's disease and other dementias are invited to attend. Some of the highlights of this two and one half day program include a presentation by Suzanne Tyas from the University of Kentucky on the Nun Study, Vladimir Hachinski from the University of Western Ontario on Vascular Dementia: Sorting through the confusion, John Morris, Washington University School of Medicine and Howard Chertkow, McGill, debating on Mild Cognitive impairment. David Conn, University of Toronto and Linda Teri, University of Washington, will be speaking

on the pharmacological and non-pharmacological approaches to BPSD. A variety of workshops for small group learning are included in the program.

The Second Canadian Colloquium on Dementia is sponsored by the Canadian Academy of Geriatric Psychiatry, the Canadian Neurological Society, the Canadian Geriatric Society and the Consortium of Canadian Centres for Clinical Cognitive Research (C5R). It is approved as an accredited group learning activity as defined by the Maintenance of Certification of The Royal College of Physicians and Surgeons of Canada. This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for 13.5 Mainpro-M1 credits. Abstract Submissions in the area of Alzheimer's Disease and other dementias will be considered for the poster session. Further information about the CCD can be viewed at